



UCSF Benioff Children's Hospitals

Improving Obstetric Triage

*Strategies to Promote
Timely, Safe, and Cost Effective Care*

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Obstetric Triage: Objectives

- Review perinatal triage including definitions and goals
- Compare and contrast medical-legal implications of telephone and outpatient triage care
- Determine the right time for a woman to transition from her home to the hospital for birth
- Describe how the anticipatory care provided by the obstetric triage nurse can prevent a complication from becoming a crisis



UCSF Benioff Children's Hospitals

History of Triage, Legal Considerations, EMTALA

History of Triage



- French origin – to choose sort or classify
 - First use in Medicine during WWI
- 1960's - used in hospital emergency rooms
 - Obstetric triage began in 1980's
- Labor wards overburdened with patients that would not go onto deliver
 - Increased Patient volume in OB
 - Frees up critically needed labor beds
- Need for heightened maternal/ fetal surveillance
- Assessment of labor
- More effective utilization of staff and resources

Benefits of OB Triage Units

- Improves patient flow
- Decreases turn over costs
- Increases bed capacity
- Function as a holding unit
- Becomes the Gatekeeper to L&D

Multiple Functions of OB Triage Units

- Labor assessment and evaluation
- Decompression of labor and delivery
- Use as a holding area (busy L&D)
- Fetal evaluation and assessment
- Evaluation of medical/ OB complaints (after hours)
- Initial stabilization of OB complications
- Evaluation of OB referrals /transfers
- Triage OB telephone calls
- Selected OB procedures
- Source of OB care when normal source isn't accessible or available

Value of the Nursing Role

- 1st to evaluate
- Detect abnormal s/sx
- Alert the team
- Optimize patient outcome



LEGAL CONSIDERATIONS

EMTALA
HIPPA

OB Triage, Active Labor, and EMTALA

- Emergency Medical Treatment and Labor Act
- Signed into federal law in 1986
 - Enacted as part of Consolidated Omnibus Budget Reconciliation Act (COBRA)
- Case review
 - Claudia Thomas: 19yo G2P1 @ 36 weeks
- Overall intent to ensure emergency services
 - Regardless of: ethnicity, insurance coverage, citizenship
- Pregnant women seek care for a urgent pregnancy problem (*Instructed by their OB to go to hospital*)
 - often without a previously scheduled appointment
 - 1/3 of all OB visits = criteria to designate ED rather than OB

EMTALA:

Emergency Medical Treatment and Labor Act

Definition:

- Acute symptoms of sufficient severity (including severe pain such that the absence of immediate medical attention could pose serious jeopardy for mother or unborn child)
- A pregnant woman having contractions where there is inadequate time for transfer and may pose a health or safety threat to the mother or unborn child

EMTALA: Emergency medical condition

- Mandates all pregnant women presenting to an ER, L&D, or OB Triage unit must have a medical screening examination (MSE).

EMTALA Requirements for Emergency Medical Treatment

POLICY 6.03.09

**Patient Care EMTALA
Requirements for Emergency
Medical Treatment Issued:
September 2000 Last Approval:
December 2011**

Categories of Risk in OB Triage

■ Patient Safety

- Assessment in a timely manner
- Appropriate and complete evaluation and documentation
- Discharge from OB Triage **without evidence of**
 - Fetal well-being
 - Recognizing active labor /discharged the woman in false labor
 - Delay in timely response from consultants
 - The use of clinical handoffs

Categories of Risk in OB Triage: Patient Safety

- **Pregnant women contracting have priority**
 - Must R/O active labor
 - Avoid treatment delays – consider chain of command
- **Determine what parameters are indicated for fetal assessment**
 - Fetal monitor → reactive tracing → further fetal testing
 - Implement intrauterine resuscitative measures
- **Prompt notification to Provider**

Legal Requirements of OB Triage

1. Perform a medical screening exam (MSE)
2. If emergency exists, notify MD and begin stabilization
3. Consider patient transfer
4. Arrange proper transfer
5. Patient evaluation and treatment cannot be delayed to obtain financial information
6. Women in labor are considered unstable from latent phase through delivery of placenta

Mahmeister and Van Mullen, 2000

EMTALA: Requirements for Transfer

- Medical Screening Exam
- Stabilization within the abilities of transferring facility
- Need for services not available at transferring facility or medical benefits of transport outweigh risks or patient /responsible person requests transfer
- Contact with receiving hospital to approve / accept transport
- Written certification by request of physician of need
- Records sent with the patient
- Appropriate method of transport used

Source: EMTALA (1986) in Angeli

EMTALA : Common Violations

- Improper refusal to accept a medically stable patient
- Improper refusal for an on-call practitioner to come in to see and examine in a timely manner
- Failure to properly complete a transfer certificate
- Failure to properly inform risk/benefit of transfer
- Failure to transfer an unstable patient with appropriate equipment and personnel
- Failure for a physician to rule out false labor
- Failure to accept a patient because of lack of ability to pay
- Failure to stabilize a patient to the facilities' maximum ability prior to transfer

California Senate Bill 1152



■ Background and Purpose

- In order to standardize the level of discharge planning service hospitals provide, California Legislature passed, and the Governor signed SB 1152.
- The law took effect, January 1, 2019
- Purpose is to help prepare the homeless patient for return to the community by connecting him or her with available community resources, treatment, shelter and other supportive services
- The law does not require hospitals to find or create service that do not exist in the community.
- Documented compliance with elements of this legislation are required by 1/1/2019.

California Senate Bill 1152



▪ **Services that Must be Offered to Homeless Patients Before Discharge**

1. Physician Examination and determination of stability for discharge
2. Referral for follow up care
3. Referral for behavioral health care if it's determined that the patient requires behavioral health care
4. Food
5. Weather appropriate clothing
6. Discharge medications (prescriptions)
7. Infectious disease screening
8. Vaccinations appropriate to the presenting medical condition
9. Transportation within 30 minutes or 30 miles of the hospital
10. Screening for and assistance to enroll in affordable health insurance coverage

Recognizing Active Labor and Discharging the Pregnant Woman in False Labor

Question:

When is a woman who presents to triage with uterine contraction deemed stable?

- a) The infant and the placenta are delivered
- b) Labor contractions are gone
- c) It is certified that the woman is in false labor
- d) All of the above

Errors and Mistakes

- Individual
 - Assessment
 - Missed diagnosed
 - Improper disposition: to: ED, Home,
 - Not timely
 - Handoffs
- System
 - Long waits
 - Crowding
 - Delays in consulting
 - EMR
 - Handoffs

Recognizing active labor and transfer of pregnant woman with high risk fetus

Question:

When a woman who presents to triage with uterine contraction and fetus with a cardiac anomaly?

- a) Admit - plan for delivery, notify Pediatrician/Neo
- b) Admit - Notify Peds, Consult MFM, consider transfer
- c) Don't admit – transfer woman to Tertiary Care
- d) Have her partner drive her to Tertiary Care – it's faster



COMMITTEE OPINION

- Number 667 • July 2016
- Hospital-Based Triage of Obstetric Patients
 - *Obstetric units are urged to collaborate with emergency departments and hospital ancillary services, as well as emergency response systems outside of the hospital, to establish guidelines for triage of pregnant women*
 - *Recently developed, validated obstetric triage acuity tools may improve quality and efficiency of care and guide resource use, and they could serve as a template for use in individual hospital obstetric units.*

AWHONN

Based on info from AWHONN's Perinatal Leadership Summits and AWHONN Perinatal Staffing Data Collaborative:

- Identified need for stringent and consistent triage guidelines for pregnant women and their fetuses
- AWHONN's Obstetric Triage Science Team:
 - **Developed the Maternal-Fetal Triage Index**
 1. Support training specific to triage
 2. Monitor nursing care during triage
 - Recommendations for quality improvement audits will be included as a component of the online resources to be released. The audit tools will serve as the foundation for additional obstetric triage NCQ measures development.

AWHONN: Measure 01

Triage of a Pregnant Woman

of pregnant patients and their fetus(es) presenting to L&D for an unscheduled evaluation triaged w/i 10 minutes....

of all pregnant patients presenting to L&D for an emergency condition

AWHONN: Triage Goal

100% of pregnant patients who present to L&D reporting a real or perceived problem, or are in an emergency condition will be triaged by an RN, Midwife, or MD within 10 minutes

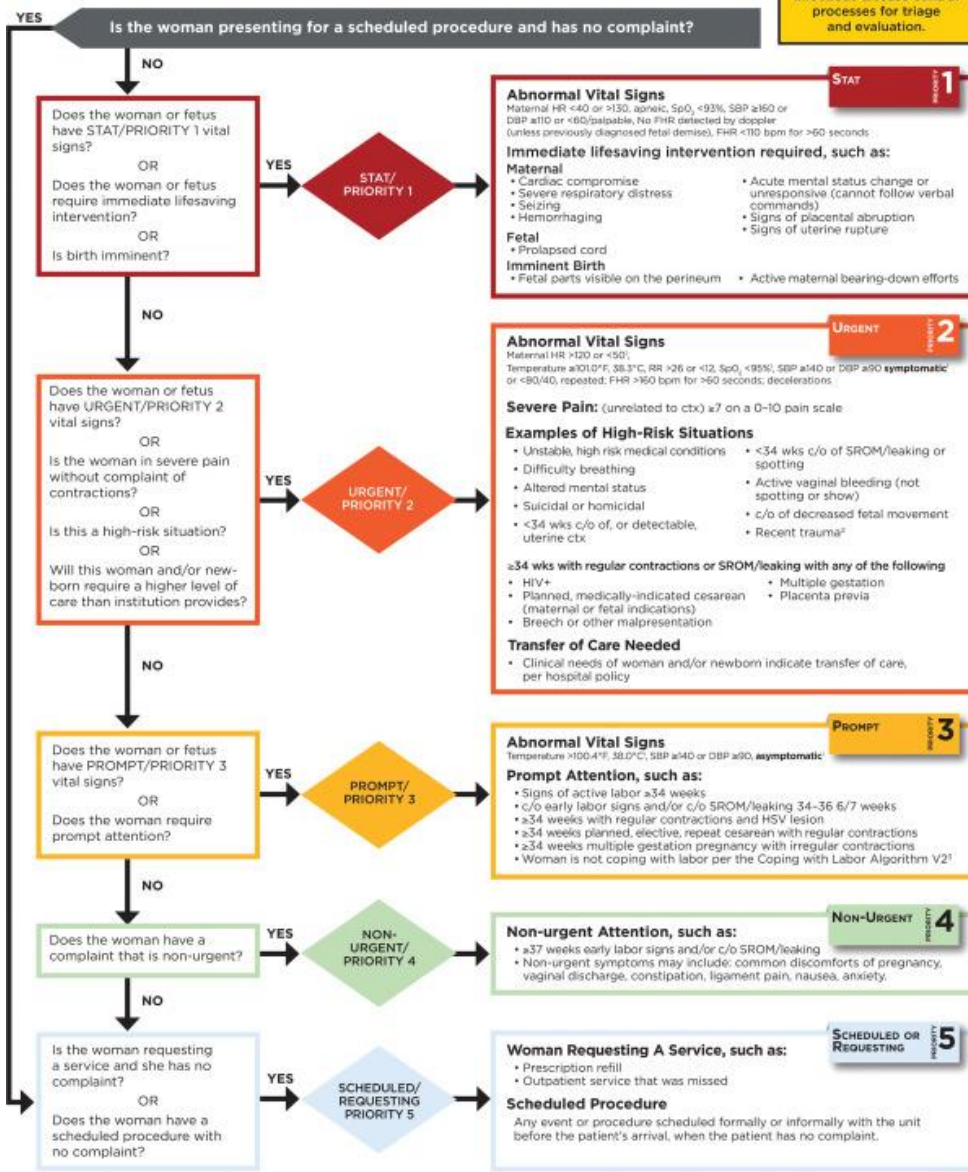
Priority: Based on the AWHONN MFTI

Question:

How often would you say this is achieved in your department?

- a) > 95%
- b) 80 - 95 %
- c) <80%
- d) <50%
- e) Not sure – No one audits or reports on this

Implement appropriate infectious disease control processes for triage and evaluation.



¹High Risk and Critical Care Obstetrics, 2013

²Trauma may or may not include a direct assault on the abdomen. Examples are trauma from motor vehicle accidents, falls, and intimate partner violence.

³Coping with Labor Algorithm V2 used with permission

The MFTI is exemplary and does not include all possible patient complaints or conditions. The MFTI is designed to guide clinical decision-making but does not replace clinical judgement. Vital signs in the MFTI are suggested values. Values appropriate for the population and geographic region should be determined by each clinical team, taking into account variables such as altitude.

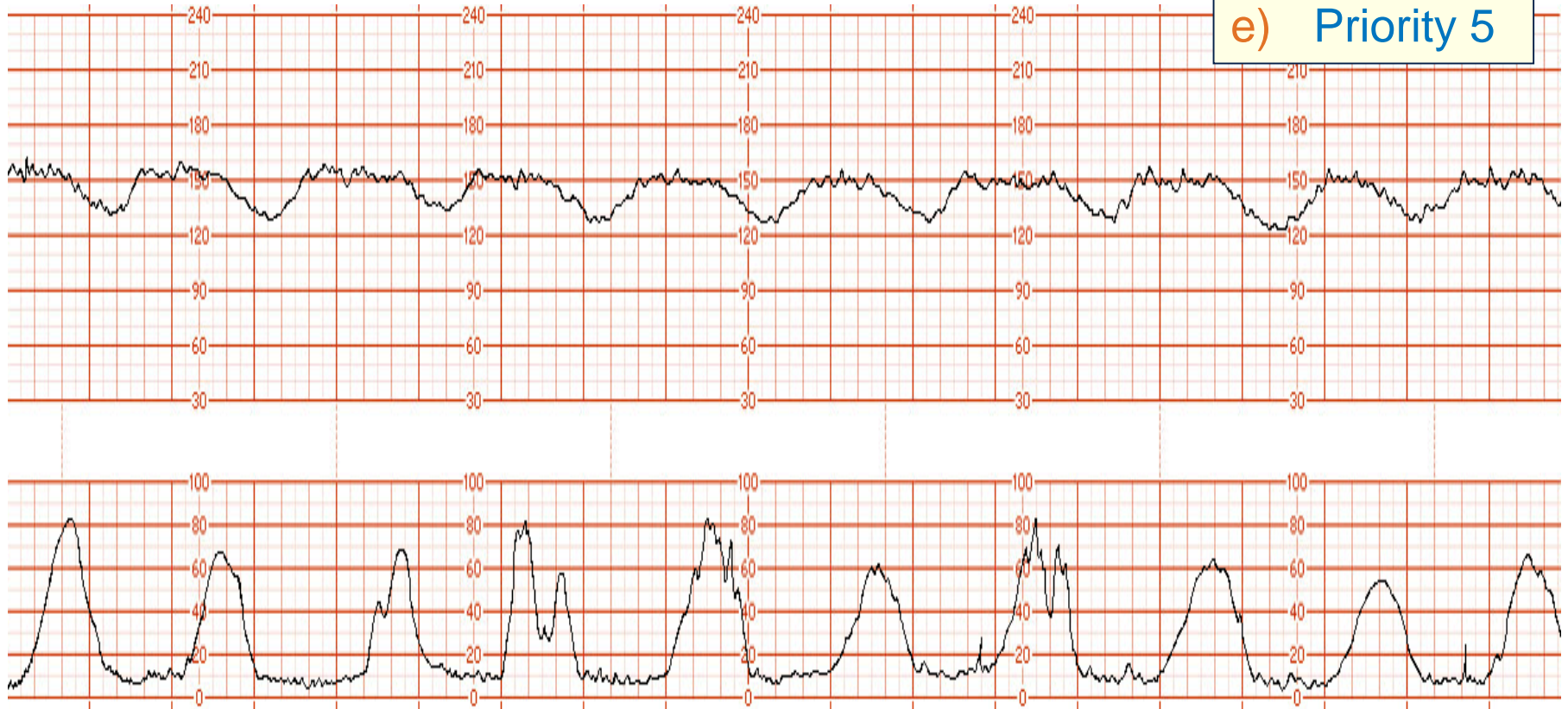
©2015 Association of Women's Health, Obstetric and Neonatal Nurses. For permission to use MFTI or integrate the MFTI into the Electronic Medical Record contact permissions@awhonn.org.

15001

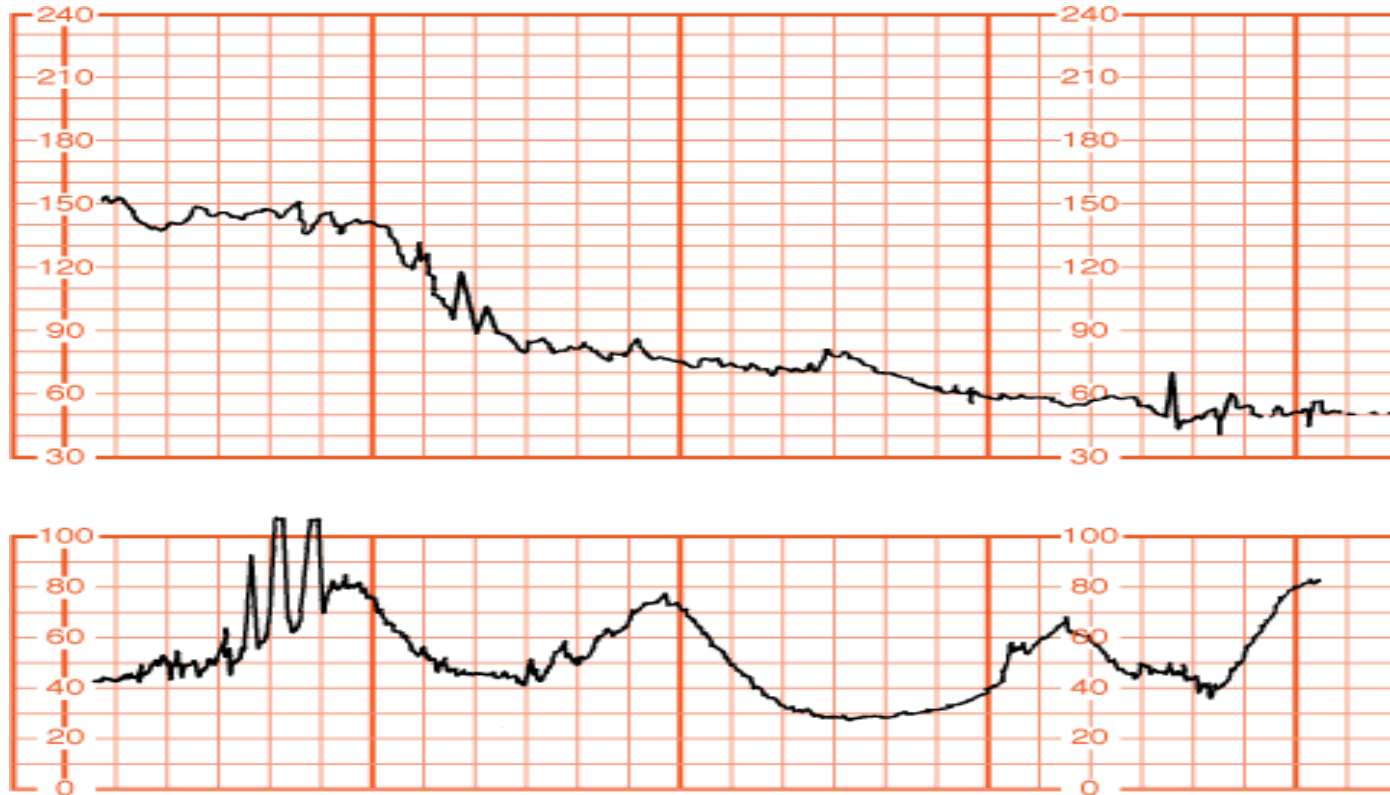


Fetal Monitoring

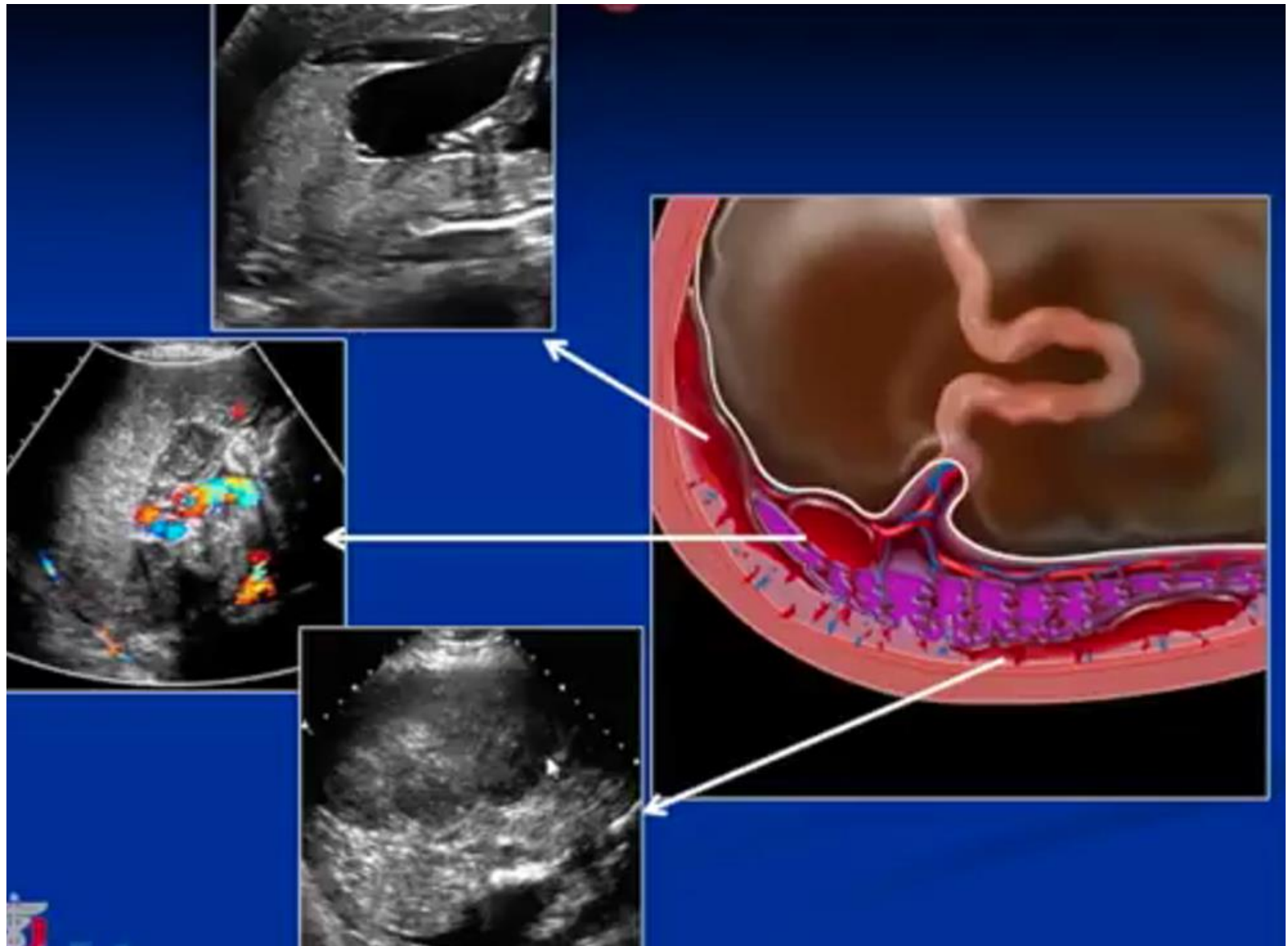
- a) Priority 1
- b) Priority 2
- c) Priority 3
- d) Priority 4
- e) Priority 5



Fetal Monitoring



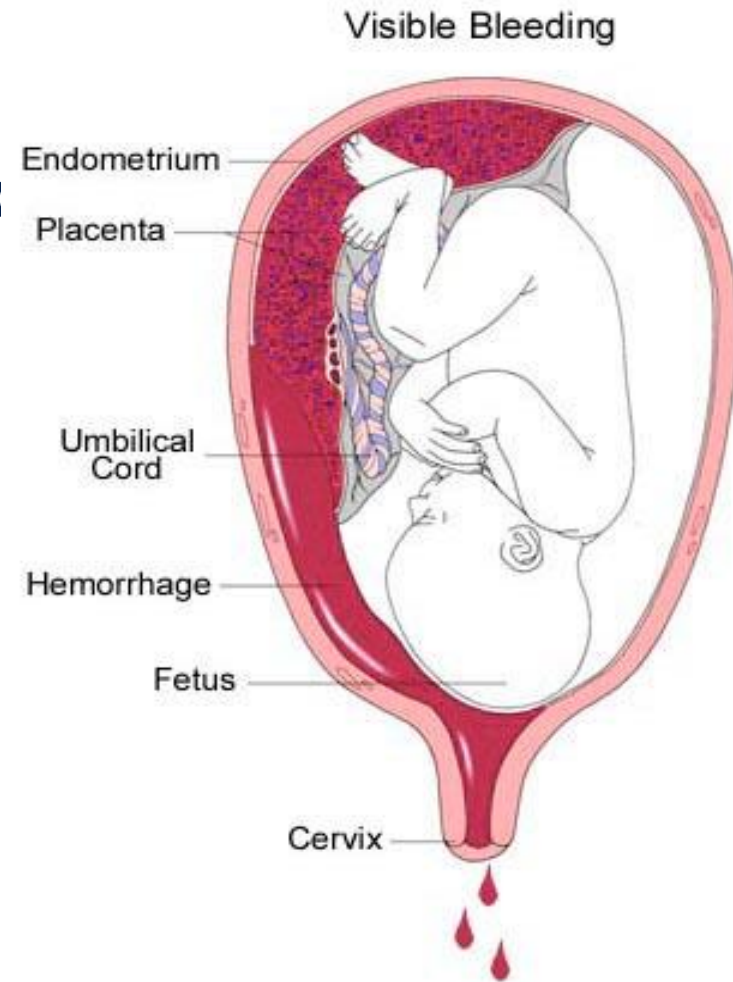
Source: Cunningham FG, Leveno KJ, Bloom SL, Hauth JC, Rouse DJ, Spong CV:
Williams Obstetrics, 23rd Edition: <http://www.accessmedicine.com>
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<https://www.youtube.com/watch?v=s729yinUGbY>

Placental Abruption

- Premature separation of a normal placenta
- Occurs in 1% of all births
- Abruption is a leading cause of hemorrhage



Management of Placental Abruption

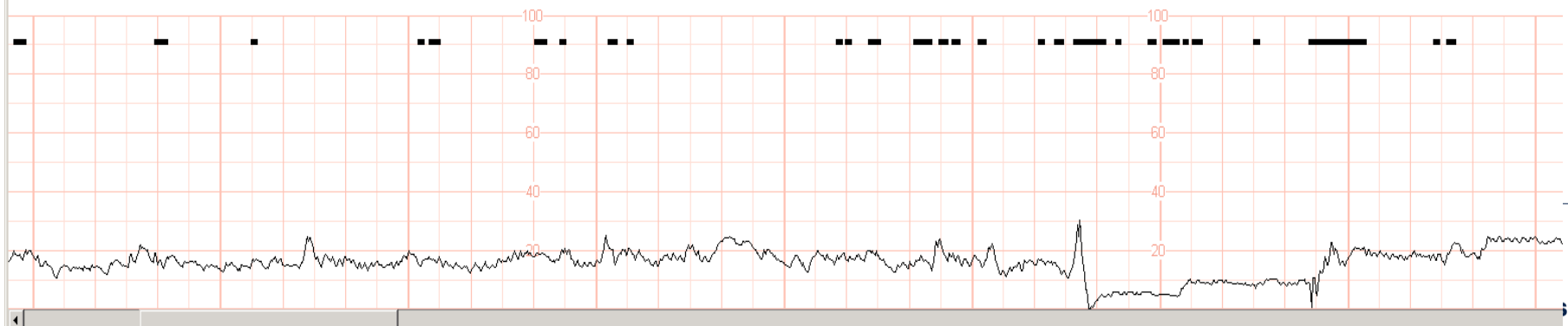
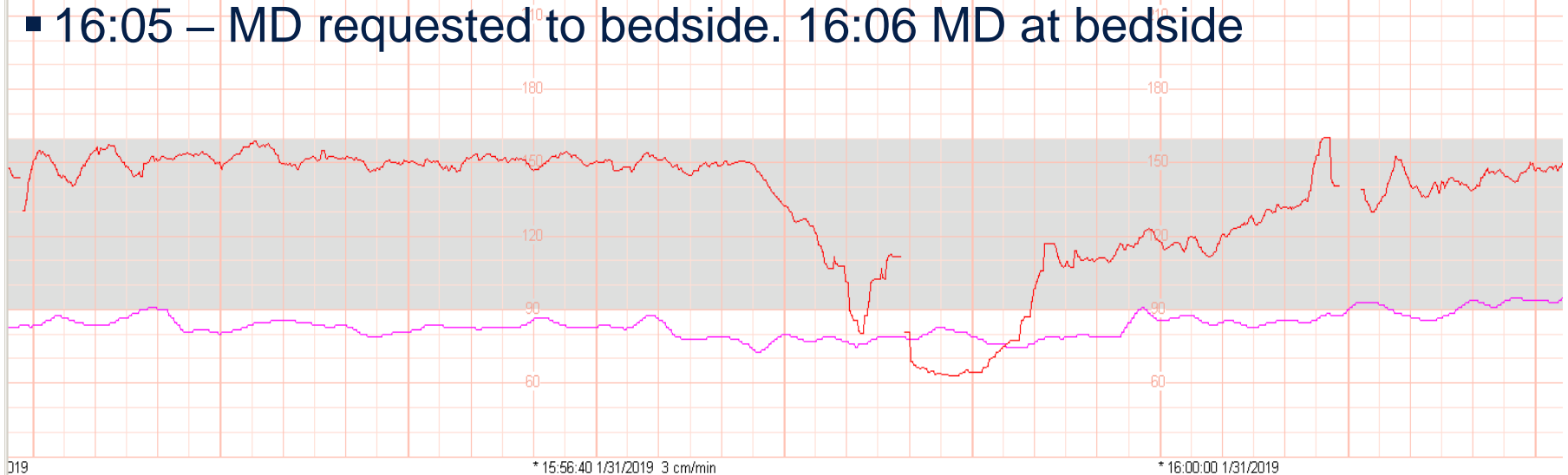
- Management based on **fetal status** and **labor status**
- Initial evaluation should include:
 - Kleihauer-Betke Test?
 - if RH negative → administer RhoGAM
 - Continuous fetal monitoring
 - Large bore IV, Type and crossmatch
 - Foley catheter??
- If the etiology is not trauma or cocaine, watch B/P, **pre-eclampsia** is the next leading cause of abruption

Question: What needs to be done

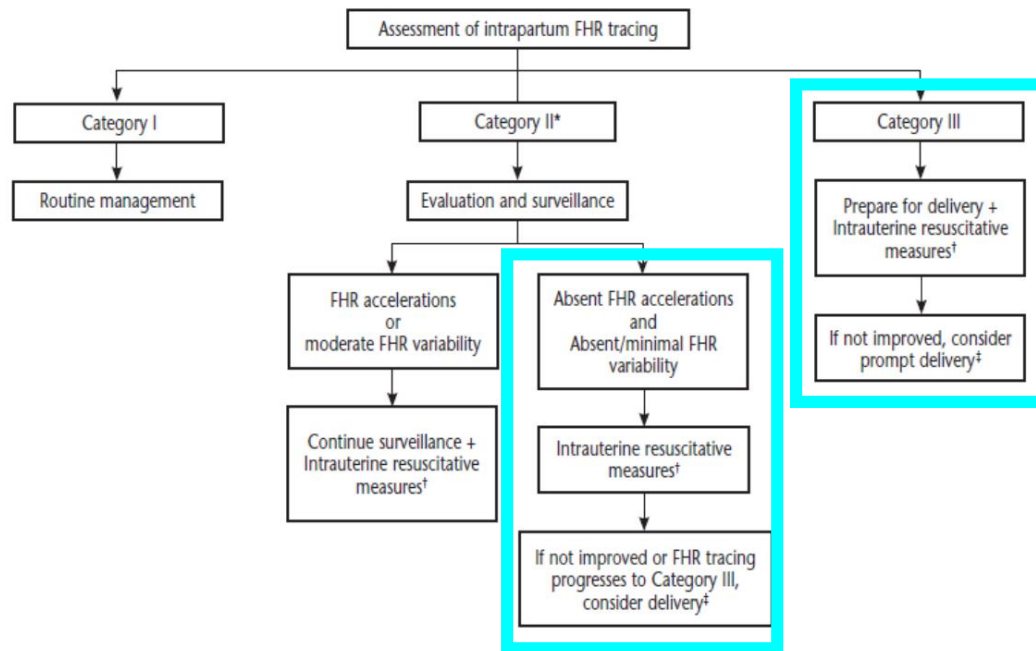
- A. Stat page Obstetrician for immediate bedside evaluation
- B. Call for additional RN help and begin intrauterine resuscitation interventions begin to prepare for possible STAT C/S
- C. Start a large bore IV, send CBC, Type & Screen
- D. All of the above
- E. All of the above plus add coagulation panel to lab tests

Decreased Fetal Movement

- G4P2012 arrived from after MD heard audible decel in office
- Hx 2 prior C/S (1)Breech, (2) Repeat, GDM with 2nd pregnancy
- 15:59 - Labor Support: Repositioning; Nurse at bedside Position: Left
- 16:05 – MD requested to bedside. 16:06 MD at bedside



Timely Intervention of non-Category 1



*Given the wide variation of FHR tracings in Category II, this algorithm is not meant to represent assessment and management of all potential FHR tracings, but provide an action template for common clinical situations.

† See Table 2 for list of various intrauterine resuscitative measures

‡ Timing and mode of delivery based on feasibility and maternal-fetal status

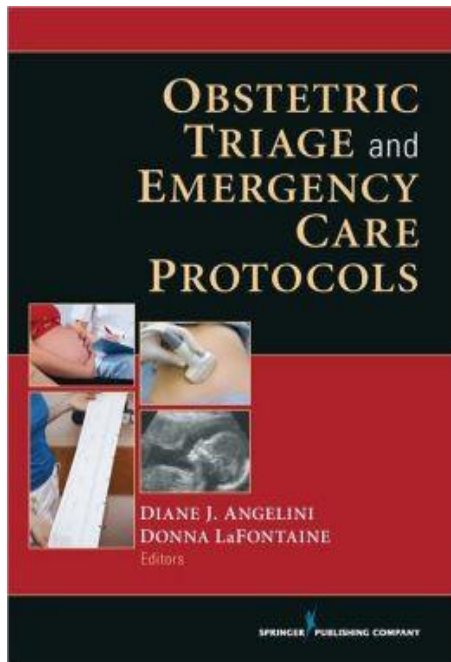


Decreased Fetal movement

- Prioritized ahead of women that present with non-emergent issues
- Immediately place patient on the monitor
- If no FHT's, notify MD immediately
- Obtain U/S machine - check for cardiac activity
- If fetal heart rate present, begin NST
- If FHR tracing is abnormal initiate intrauterine resuscitative measures in triage
 - IV Fluids, O2, reposition, tocolytics, prepare for C/S
- If non reactive NST
 - Consider extended monitoring
 - complete AFI/BPP before DC home

Literature Review

- Focus on advanced practice nurse models
- Limited regarding staff RN in triage



Angelini, D.J. & LaFontaine, D. (Eds.) (2013)
*Obstetric Triage and Emergency Care
Protocols.* Springer; New York.

Obstetric Triage: Objectives

- Compare and contrast medical-legal implications of telephone and outpatient triage care
- Determine the **right time** for a woman to transition from her home to the hospital for birth
 - **5-1-1 rule** (5 minutes apart, lasting 1 minute, for 1 hour)
 - Recent recommendations 4-1-1 or even **3-1-1** (Lamaze Intl.)
- Explore verbal and written **discharge to home instructions**
 - Most women report they feel most comfortable at home
 - Freedom of movement
 - Able to do things for themselves

UCSF False Labor Exceptions for Admission

- Patient offered to walk for 2 hours and cervix rechecked to see if labor is progressing
- Reactive NST and patient is stable they can go home and return when labor is more active
- Patient/partner is given more comfort support instruction by nurse on positions and activities that promote laboring at home
- Prodromal labor:
 - Patient is admitted if agreeable to be augmented with Pitocin or misoprostil
 - Offered pain management with morphine and Phenergan cocktail encouraged to go home and return when labor more active

Multiple Functions of OB Triage Units

- Labor assessment and evaluation
- Decompression of labor and delivery
- Use as a holding area (busy L&D)
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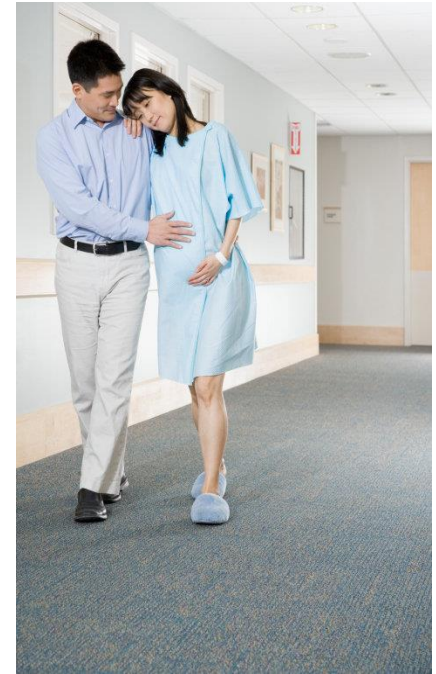
Hospital Triage: Review Assessments & Interventions



- Labor Evaluation
- ROM
- Contraction pattern
- Frequency/ Intensity
- Discomfort in lower abdomen, back, and groin
- Does activity effect or ↓ UC's
- Cervical change
- Latent phase
 - Long contraction phase
 - Sedation decreases or stops contractions
 - Bloody Show usually not present

True v/s False Labor Status

- Onset of labor is established by observing progressive cervical change
- Two or more cervical exams, separated by adequate time
 - Conflicts between patient perception And the nurses definition of labor
 - Nurses are a valuable source of information and support



Powers, Passage, Passenger and: Personality

- Coping Skills
- Learning Style
- Pain Management
- Patient Education and preparation



Owen Franken / Corbis file

Toolkit: Implement Early Labor Supportive Care Policies and Active Labor Criteria for Admission

- Translation: Early labor at home. Let labor start on its own!
- **Physiologic onset of labor is critical to the success in labor**, and introduces moms and babies to protective hormonal pathways
- Women admitted in early labor are more likely to have a cesarean, and more likely to have routine interventions e.g. oxytocin even if not clinically necessary

Toolkit: Early admission support

- Admission policy or checklist for spontaneous labor
- Latent labor support and therapeutic rest policies
- Patient education materials to explain rationale for delayed admission, reduce anxiety and provide guidance on when to return to the labor and delivery unit
- Material with specific guidance for partners and family members as to how to best support the woman in early labor

The Toolkit is Aligned with the ACOG/SMFM Consensus Statement and the AIM Patient Safety Bundle



- Readiness

- Recognition and Prevention

- Response to Every Labor Challenge

- Reporting



SAFE REDUCTION OF PRIMARY CESAREAN BIRTHS: SUPPORTING INTENDED VAGINAL BIRTHS

READINESS

Every Patient, Provider and Facility

- Build a provider and maternity unit culture that values, promotes, and supports spontaneous onset and progress of labor and vaginal birth and understands the risks for current and future pregnancies of cesarean birth without medical indication.
- Optimize patient and family engagement in education, informed consent, and shared decision making about normal healthy labor and birth throughout the maternity care cycle.
- Adopt provider education and training techniques that develop knowledge and skills on approaches which maximize the likelihood of vaginal birth, including assessment of labor, methods to promote labor progress, labor support, pain management (both pharmacologic and non-pharmacologic), and shared decision making.

RECOGNITION AND PREVENTION

Every patient

- Implement standardized admission criteria, triage management, education, and support for women presenting in spontaneous labor.
- Offer standardized techniques of pain management and comfort measures that promote labor progress and prevent dysfunctional labor.
- Use standardized methods in the assessment of the fetal heart rate status, including interpretation, documentation using NICHD terminology, and encourage methods that promote freedom of movement.
- Adopt protocols for timely identification of specific problems, such as herpes and breech presentation, for patients who can benefit from proactive intervention before labor to reduce the risk for cesarean birth.

PATIENT SAFETY BUNDLE

Safe Reduction of Primary Cesarean Births



Children's Hospitals

Newer Data

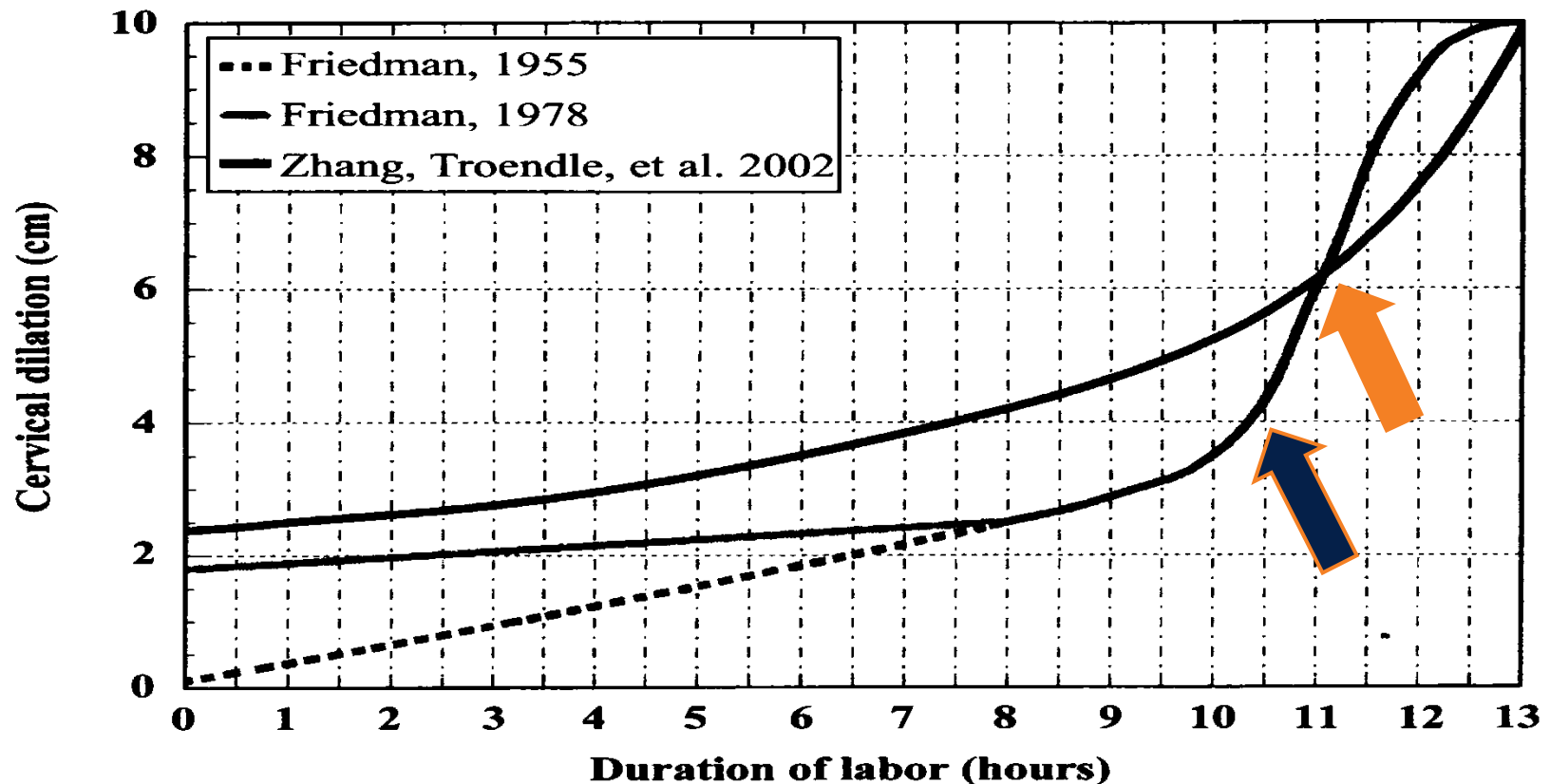
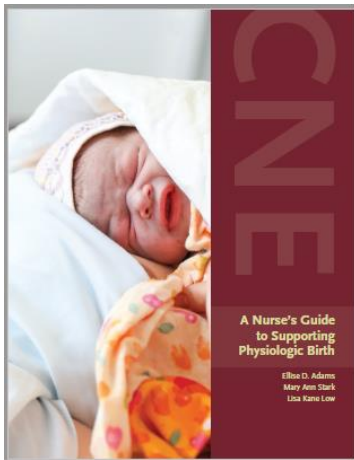


FIGURE 36-1 ■ Comparison between Friedman labor curves and the pattern of cervical dilation. (Data from Zhang J, Troendle J, Yancey MK: Reassessing the labor curve in nulliparous women. *Am J Obstet Gynecol* **187**:824, 2002. Printed with permission from CV Mosby.)

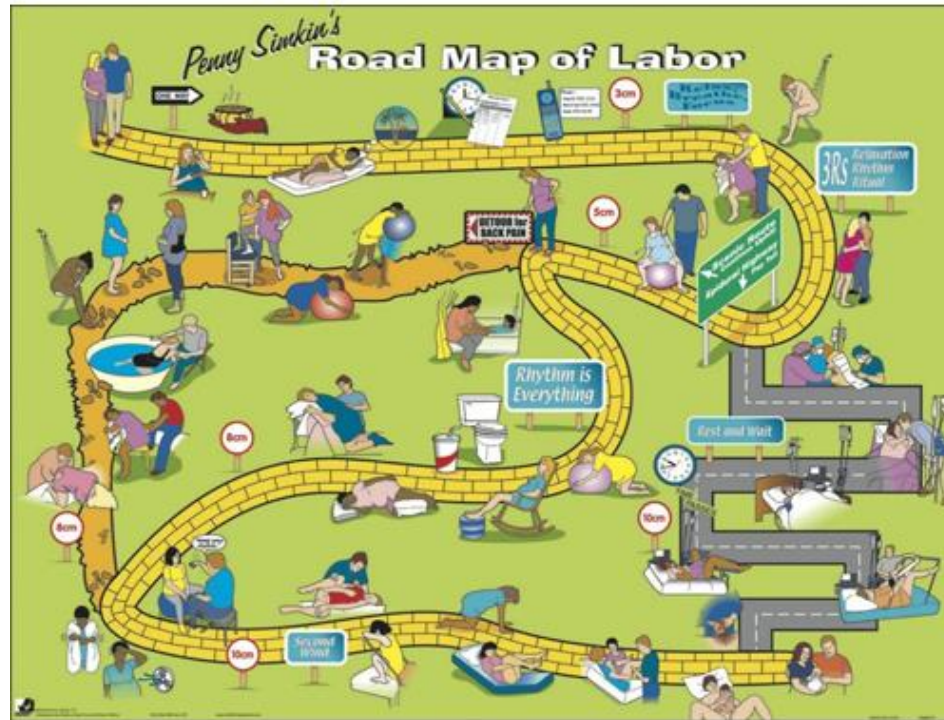
What UCSF patients are doing



- Walk
- Go home with discharge instructions – (See UCSD handout)
 - What does early labor feel like
 - What can I do for comfort in early labor
 - What should I eat/drink in early labor
 - What can I do if I need more help coping with early labor
 - When should I call or come back into the hospital



Resources to Support Normal Birth



© Penny Simkin

Keep Calm and Labor On! *Know what to expect in early labor*



Oh baby! You just had your first contraction.
Is this it? Should you grab your birthing bag and head out?

You may be in **early labor** — the phase that comes before **active labor**.

WHAT HAPPENS IN EARLY LABOR?!

- Hormonal changes to prepare for birth and breastfeeding
- Cervix dilates to 6 cm to prepare for childbirth
- Longest phase, more than half of the total labor time
- Contractions start off mild, may last 30-45 seconds about every 5 minutes, then become longer, stronger and closer together
- May start and stop several times before active labor — can last from a few hours to a few days
- Baby begins to lower into pelvis



DID YOU KNOW?

The average length of early labor is 6-12 hours for first-time moms (early labor is usually shorter for experienced moms). It may even last 24 hours or more, which can be perfectly normal.

THERE ARE BENEFITS TO STAYING HOME DURING LABOR AS LONG AS POSSIBLE:



Gives you time flexibility to move freely—helps to reduce the risk of medical interventions!



Helps increase the labor hormone, oxytocin—which causes the cervix to thin and open!

HOW CAN YOUR PARTNER OR DOULA SUPPORT YOU?



Offering comfort, physical care and reassurance



Helping time instructions (Lamaze's Pregnancy is Powering Us) and the 4-1-1 rule



Keeping your mind off labor with phone activities, the internet, games

STAY COMFORTABLE BY:



Resting and relaxing



Drinking plenty of fluids and eating what appeals to you



Going for a short walk



Moving around or changing positions



Focusing on slow, deep breathing



Using a warm pad or hot pack on your lower back



Reading a good book or watching TV



Asking your husband or partner for a gentle massage



GET THE 4-1-1 ON WHEN TO GO!

Active labor begins when contractions are roughly 4 minutes apart, last 1 minute and have been that way for 1 hour! However, listen to your body. If you feel it's time to go to your birthing facility, follow that instinct and/or call your care provider first—especially if your water breaks.

Learn more about early labor in a Lamaze class, in-person or online, so you can be prepared!

PUSH FOR THE SAFEST, HEALTHIEST BIRTH POSSIBLE. VISIT WWW.LAMAZE.ORG/PUSHFORYOURBABY TO LEARN MORE.



1. Lamaze, L. (2015). *The Lamaze method of childbirth preparation*. (3rd ed.). New York: The Lamaze Institute.
2. American College of Obstetricians and Gynecologists. (2015). *Obstetrics*. (2nd ed.). Washington, DC: American College of Obstetricians and Gynecologists.
3. American College of Obstetricians and Gynecologists. (2015). *Obstetrics*. (2nd ed.). Washington, DC: American College of Obstetricians and Gynecologists.
4. American College of Obstetricians and Gynecologists. (2015). *Obstetrics*. (2nd ed.). Washington, DC: American College of Obstetricians and Gynecologists.
5. American College of Obstetricians and Gynecologists. (2015). *Obstetrics*. (2nd ed.). Washington, DC: American College of Obstetricians and Gynecologists.



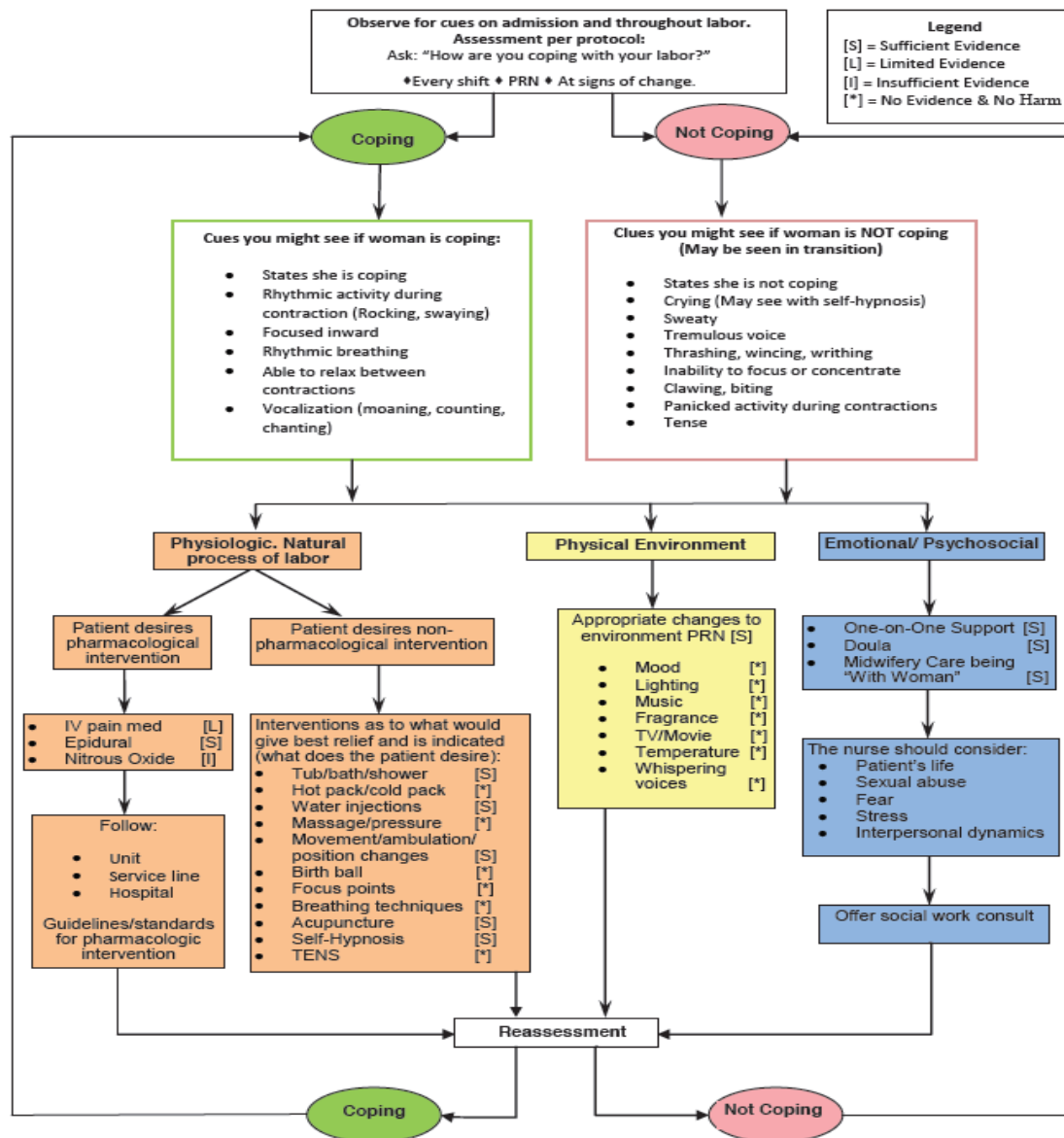
UCSF Benioff Children's Hospitals

STAY COMFORTABLE BY:



- Intimate support
 - partner and/or doula
- Ambulation
 - position changes
 - birth ball
 - yoga mats
- Rebozo
- Therapeutic shower
 - Tub bath
- Acupressure, massage
- Rocking Chair
- Nutritional support

Coping with Labor Algorithm v2 ©



EPIC: Coping verses Not-coping IN LABOR !

Summary

Chart Review

Care Everywhere...

Results Review

MAR

Flowsheets

Intake/Output

Notes

Education

Care Plan

Growth Chart

Orders

Advanced Care...

Delivery Summary...

Navigators

Charges

More

Labor Communication Procedure/Time Out IV Assessment I/O Physical Assessment Delivery Preferences Recovery PACU Antepartum Cares/Safety Patient Belongings Labor

Jump To (Alt+Comma)

Hide All Show All

HEMORRHAGE RISK

LABOR ASSESSMENT

VITALS

SEPSIS SCREEN

PAIN ASSESSMENT

Pain Management (Labor)

Pain Assessment (Non-Labor)

EFM

OXYTOCIN

CERVICAL EXAM

MEMBRANES

VAGINAL BLEEDING

ADDITIONAL TESTS

PERIPHERAL IV

EPIDURAL

GLUCOSE ASSESSMENT

NST

LAST PO INTAKE

LDA

FORMULA

OTHER

Accordian Expanded View All

1m 5m 10m 15m 30m 1h 2h 4h 8h 24h Based On: 0700 Reset Now

Admission (Current) from 3/2/2019 in MV MCH LABOR DELIVERY

3/3/19

	1900	1930	1931	1946	2000	2016	2030
Temp							37.1 (98.8)
Temp src							Oral
Pulse	99		92	102	97		101
Resp					18		18
BP	166/92		169/90	150/86	146/85		140/81
MAP	108		109	99	98		93
SpO2							
Oxygen Device							

Perinatal Sepsis Screen - For Patients 14 Weeks Pregnant through 4 Weeks Postpartum

Suspect new or worsening infection?

NEW Signs and Symptoms present

Sepsis Alert called for 2+ NEW S/S

Pain Management (Labor)

Labor Pain Score

Pain Nonverbal

Labor Response

Labor Support

Maternal Position

Labor Pain Relief

Pain Assessment (Non-Labor)

Pain Assessment

Pain Score

Pain Type

Pain Location

Pain Orientation

Pain Radiating Towards

Pain Descriptors

Pain Frequency

Pain Onset

Clinical Progression

Other (Comment)

Other (Comment) (consistent with H/A) by Valerie Y Huwe, RN at 03/03/19 2030

Pended

EPIC: Coping verses Not-coping IN LABOR !

Summary

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Hide All Show All

HEMORRHAGE RISK

LABOR ASSESSMENT

VITALS

SEPSIS SCREEN

PAIN ASSESSMENT

Pain Management (Labor)

Pain Assessment (Non-Labor)

EFM

OXYTOCIN

CERVICAL EXAM

MEMBRANES

VAGINAL BLEEDING

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Maternal Position

Labor Pain Relief

Pain Assessment (Non-Labor)

Pain Assessment

Pain Score

Pain Type

Pain Location

Pain Orientation

Pain Radiating Towards

Pain Descriptors

Pain Frequency

Pain Onset

Clinical Progression

Effect of Pain on Daily Activities

03/03/19 2016

Labor Support

Select Multiple Options: (F5)

Repositioning

Nurse presence at bedside

Reassurance

Instructed in breathing technique

Instructed in relaxation technique

Pelvic rocking

Rhythmic activity during contraction

Massage: back/shoulder

Counterpressure

Hip squeeze

Fluids

Nutrition offered

Bath hydrotherapy

Shower hydrotherapy

Visualization

Aromatherapy

Massage: hands/feet

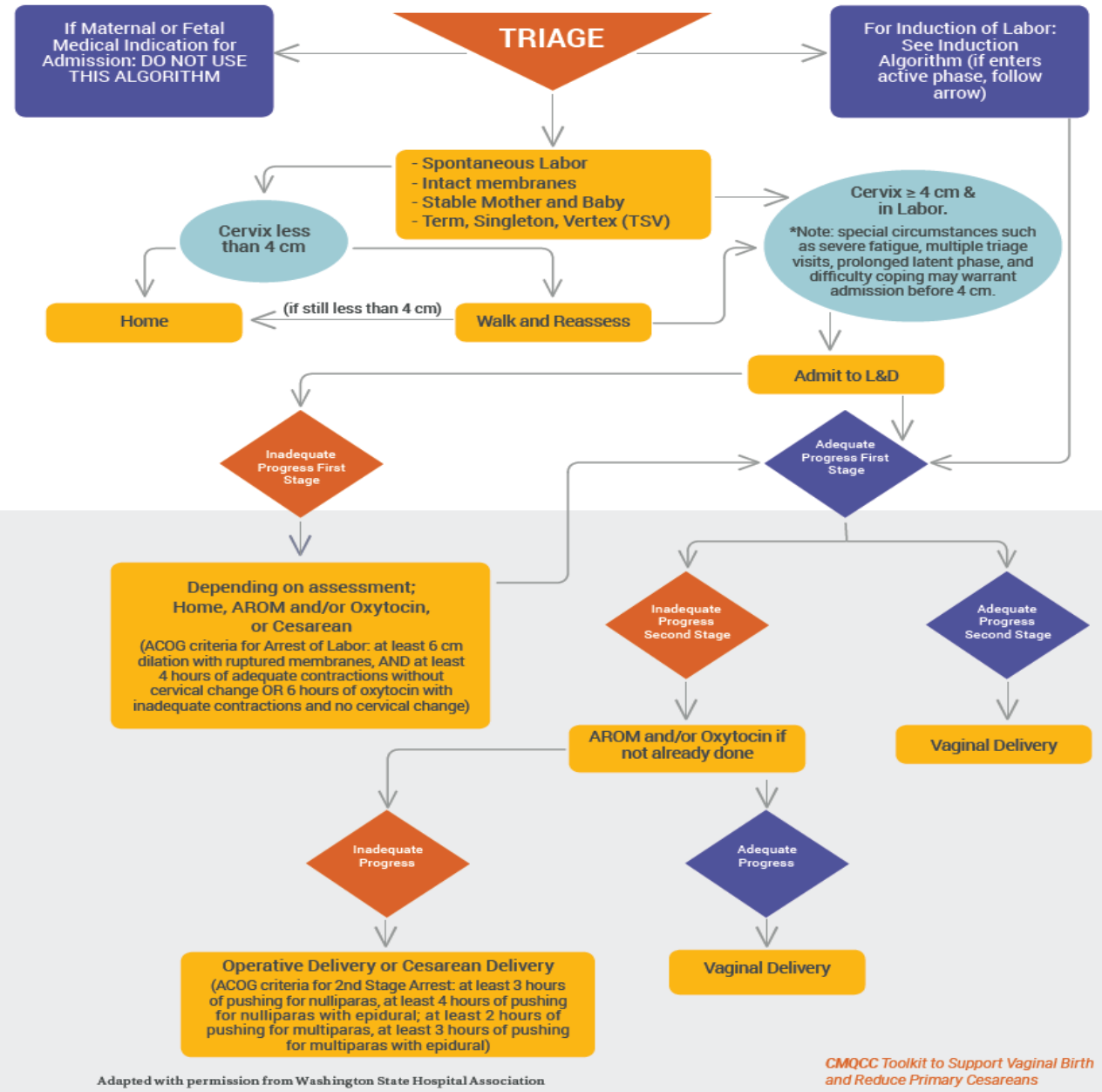
Promote calm environment

Other (Comment)

Comment (F6)

Appendix M

Spontaneous Labor Algorithm



Discharge for latent phase

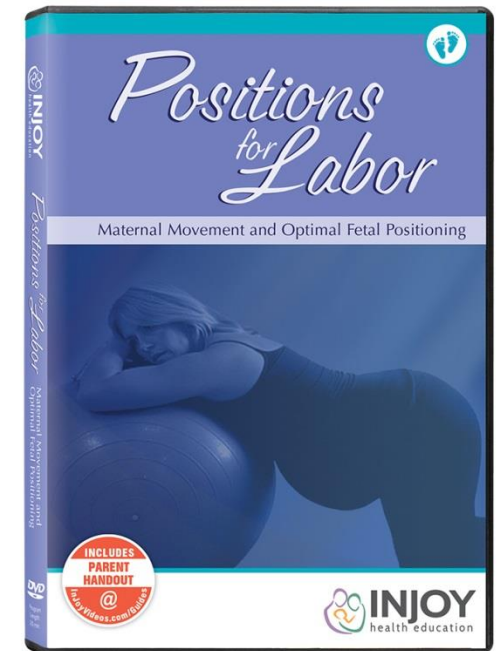
- Eat easily digested foods, drink plenty of fluids
- Alternate activity with rest and take nice walks
- Prepare last minute things for baby
- Surround yourself with people that help you feel comfortable
- Relax with a warm shower
- Listen to music to maintain a tranquil environment
- Ask your partner for a massage
- If unable to talk during a contraction begin a slow chest breathing pattern
- Listen to you body and follow your instinct when it's time to come back to the hospital

Therapeutic rest



- Protocol
- Morphine Phenergan dosing
- Trial in progress

Resources



Impact of Collaborative Management and Early Admission in Labor on Method of Delivery

J • Prospective study (2,196)

- Fewer (23.4 %) admitted in labor <4 cm when co-managed with midwife
- Women admitted in in early labor (<4 cm) had fewer vaginal deliveries
- Conclusion: Later admission in labor (>4 cm) and collaborative care MD/CNM increased rate of NSVD

Improving Satisfaction with Care and Reducing Length of Stay in an Obstetric Triage Unit Using a Nurse-Midwife-Managed Model of Care

Paul, J., et al. (2013) *Journal of Midwifery & Women's Health*

- A QI project in a north east tertiary-care hospital in US
 - Shorten length of stay / improve patient satisfaction
 - Comparative design: Standard Care v/s CNM Model
 - 272 Women: 121 Standard care – 151 CNM Model
 - Measured with validated questionnaire
 - based on Molloy and Mitchell, BJM 2010

Improving Satisfaction with Care....

Obstetric Triage with CNM Model of Care

Paul, J., et al. (2013) *Journal of Midwifery & Women's Health*

- Women in the CNM managed group were significantly more likely to be extremely satisfied with 5 of 6 aspects measured
 1. Wait time for provider
 2. Time spent with provider
 3. Length of visit
 4. Overall care received
 5. Overall triage experience

ESTABLISHING PHONE TRIAGE

- ✓ EDUCATION
- ✓ COMPETENCY
- ✓ DOCUMENTATION

Phone Triage

Question:

Does your Department have a formal phone triage policy and procedure ?

- a) No we instruct the patient to call their doctor
- b) No but we informally guide them over the phone
- c) Yes formal P&P with written documentation
- d) Not sure – we’re kind of “winging it” no formal training
- e) Other

Phone Triage for Labor

Department guideline?

Gestational age

Complications of pregnancy

ROM

Mucous/Bloody Show

Uterine activity

Recent cervical exam

Fetal Movement

Assess stay home & call back or come in

Notify MD / CNM



“Welcome policy”

Competence Assessment

- L&D Nurses must complete a series of competence assessments with qualifying exams
 - This education material was based on current evidence and practice standards
 - Emphasis on triage as a systematic approach to rapid patient assessment
 - Assigns priority on the degree of need
 - Primary goal for triage nurse to assign acuity within 10 minutes of arrival to the unit
- Once the educational requirements the nurse is deemed “Triage competent”

BASIC CONSIDERATIONS IN ESTABLISHING A TELEPHONE TRIAGE SYSTEM

1. Are “Protocols” or “Guidelines” an Appropriate Format?
2. What's the First Step in Drafting Protocols or Guidelines?
3. Who Should Handle the Calls?
4. How Should Calls Be Documented?
5. What Information Is Pertinent for Each Patient Who Calls?
6. Health Insurance Portability and Accountability Act (HIPAA)
 - Speak to the patient, check MR for authorization, confidential record
7. Reducing legal risks/improving patient care
 - Adequately trained staff, protocols in writing, proper documentation

Telephone Triage for Obstetrics and Gynecology, 2010. Philadelphia

Vicki E. Long MSN, CNM, RN, Patricia C. McMullen PhD, JD, WHNP-BC, RN



UCSF Benioff Children's Hospitals

UCSF

Perinatal Telephone Triage Record

Age, G_P_, EDC, Reason for call, Previous treatment

Current Pregnancy Medical Complications:

- None
- PTL
- HTN
- GDM
- Breech
- Previous C/S
- Twins
- Hyperemesis



Assessment: R/O PTL, SRM, Preeclampsia ...

Disposition/ Plan

Instructions to patient – come in, stay home, when to call back
F/U from patient, document date and time

UCSF Telephone Triage

- Staff Nurse Patsy Creedy RN, BSN
- Provides triage education to select L&D staff
 - Definition and History
 - Who Calls
 - What Do They Call About ?
 - Johnson and Johnson Study(1990)
- May eliminate unnecessary trips to the hospital
- Informational

UCSF OB Phone Triage:

3 Recommendations

1. Only Triage trained RN's can answer calls
2. Use standardized phone interview
3. Discussion, Disposition, and Documentation

UCSF OB PhoneTriage: Medical Legal Aspects

- American College of Emergency Physicians recommends against diagnosis or treatment by phone
- When in doubt, go to ED or L&D
- Ok to respond to D/C questions-instructions, meds, referrals, first-aid info
- Advice given only by qualified medical professionals
- Quality assurance-policies, protocols, documentation, to monitor outcomes
- Controversy exists over legal parameters

UCSF OB TRIAGE: Accountability

- Conscientious use of department guidelines
- Complete documentation
- Adherence to standards
- Quality assurance guidelines

UCSF OB TRIAGE: Standard of Care

The level of care that would be given by a reasonably prudent nurse under the same or similar circumstances

UCSF OB TRIAGE:

Elements of Negligence

- Duty to behave reasonably
- Negligence - failure to act reasonably AND results in injury
- Must provide proof that the person accused failed to act reasonably when they had a duty to do so
- The failure to act reasonably caused an injury related to the breach of duty
- When a nurse fails to do what a reasonably prudent nurse would do under similar circumstances, the standard of care is considered breached

UCSF OB TRIAGE: Duty to Terrify

- Tennenhouse 1988
- “Duty to terrify is a duty based on the liability from an injury to the noncompliant patient who claims that his or her noncompliance was due to an inadequate understanding of the urgency of the situation.”
- Nurses must err on the side of caution when in doubt
- Directives should be specific enough to convey urgency

<http://teletriage.com>

UCSF OB Phone Triage: Working Diagnosis

- Neither MD's or RN's can diagnose without an exam
- Acceptable to form initial impressions “working diagnosis”
- Identify symptoms and classify by acuity rather than seeking to determine specific causes of symptoms
- The MD or RN must always inform patient of the presumptive status of this evaluation
- Use language the client can understand

UCSF OB Phone Triage: Communication

Goal of Telephone triage:

- **Listen - receive information**
- **Assess - acute verses non-acute**
- **Give and receive information**
- **Release anxiety - inspire, persuade engender trust**
- **Problem solve**

UCSF OB TRIAGE:

Effective Telephone Technique

- Good communication depends on receiving information as much as on sending it
- The manner of communication is almost as important as what is communicated
- Inspires, persuades, engenders trust

UCSF OB Phone Triage: Telephone Charisma

- Self disclosure
- Empathy
- Respect
- Warmth
- Authenticity
- Compassion

UCSF OB Phone Triage: Respecting the Patient

- Allow enough time
- Open-ended questions
- Create a safe, understanding atmosphere
- Do not patronize the patient or belittle the problem
- Patient satisfaction can build patient independence and foster additional learning

UCSF OB Phone Triage: Common Practice Errors

- Using leading questions
- Using medical jargon
- Inadequate data collection
- Stereotyping patients or problems
- Failure to talk directly to the patient
- Patient self-diagnosis and second guessing
- Don't devalue reassurance calls

UCSF OB TRIAGE:

Three Stages of a Triage Call

- **Stage One: Gathering Data**
 - Spend at least 2-3 minutes gathering data
 - Active listening vs. passive listening
 - Open-ended questions vs. leading questions
- **Stage Two: Confirmation**
 - Clarify
 - Reiterate
 - Formulate a working diagnosis
- **Stage Three: Disposition**
 - Classify the problem
 - Provide protocol advice
 - Make a plan
 - Ask patient if they have any more questions
 - Have patient reiterate instructions/plan when necessary

Phone Triage for Term Labor

- Janssen, Still, Klein, et al. (2006). University of British Columbia, Canada
Early labor assessment and support at home versus telephone triage: a randomized controlled trial. Obstetrics and gynecology, 108(6), 1463-1469.
LEVEL OF EVIDENCE: I
- 731 women were managed by a telephone triage nurse
- 728 women received a home visit
 - C/S Rates
 - Narcotic, epidural analgesia
 - Augmentation of labor
- Significantly fewer women were admitted < 3 cm's
- Significantly more women managed their labor without a visit to the hospital for assessment
- What about Costs?



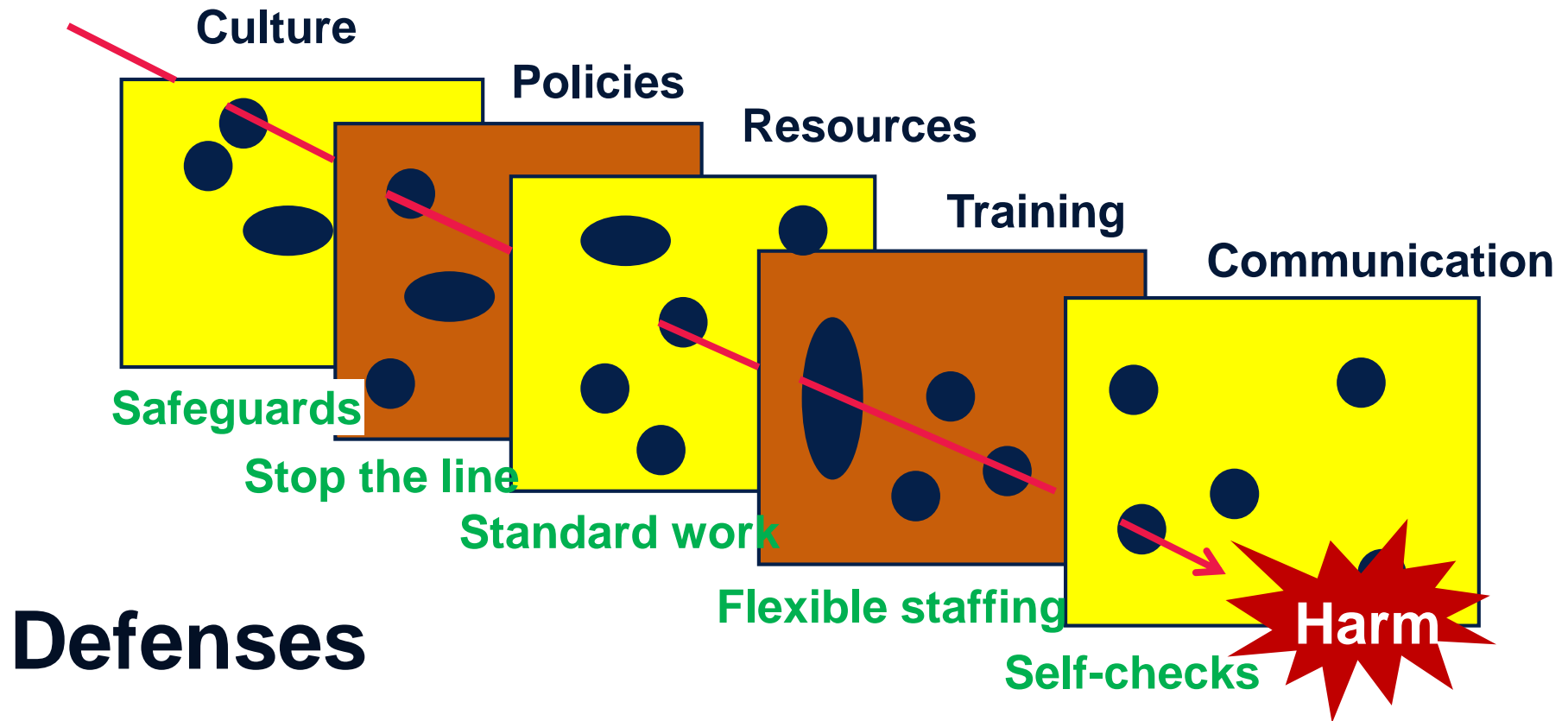
no statistic significance

Case Presentation

- 05:20 Ms. Davis is admitted to L&D as an outpatient - (out of network)
- 36 yo G4 P2 at 35+3 weeks gestation
- C/O upset stomach and pain around diaphragm
- VS: 98.6, HR 68, R 18, BP 161/85, re√ 140/84,
 - **Pain 7-8/10**
- FHR tracing on L&D 05:30 – 07:33
- Baseline 140, Moderate variability, accelerations to 165 no decelerations noted (Category I)

How did this happen?

Failures



Question: What is the recommended time to wait to confirm severe range BP in Triage

- A. 5-10 minutes
- B. 15 minutes
- C. 30 minutes
- D. 1 hour
- E. You must have 2 BP measurements 4-6 hours apart to diagnose Preeclampsia with severe features

How to Accurately Measure Blood Pressure

- Patient seated comfortably, legs uncrossed, back and arm supported
- Use the correct sized cuff so that it **fits correctly** around the upper arm and line the middle of the BP cuff with the level of the right atrium (middle of the sternum)
- Patient should be **relaxed** and instructed **not to talk** during the measurement
 - Ideally a resting time of several minutes should elapse before the BP is taken
- If initial assessment elevated
 - Repeat after several minutes to determine if hypertension persists

Diagnostic Criteria

TABLE E-1. Diagnostic Criteria for Preeclampsia ↵

<u>Blood pressure</u>	<ul style="list-style-type: none">• Greater than or equal to 140 mm Hg systolic or greater than or equal to 90 mm Hg diastolic on two occasions at least 4 hours apart after 20 weeks of gestation in a woman with a previously normal blood pressure• Greater than or equal to 160 mm Hg systolic or greater than or equal to 110 mm Hg diastolic, hypertension can be confirmed within a short interval (minutes) to facilitate timely antihypertensive therapy
and	
<u>Proteinuria</u>	<ul style="list-style-type: none">• Greater than or equal to 300 mg per 24-hour urine collection (or this amount extrapolated from a timed collection) or <ul style="list-style-type: none">• Protein/creatinine ratio greater than or equal to 0.3*• Dipstick reading of 1+ (used only if other quantitative methods not available)
<u>Or in the absence of proteinuria, new-onset hypertension with the new onset of any of the following:</u>	
Thrombocytopenia	<ul style="list-style-type: none">• Platelet count less than 100,000/microliter
Renal insufficiency	<ul style="list-style-type: none">• Serum creatinine concentrations greater than 1.1 mg/dL or a doubling of the serum creatinine concentration in the absence of other renal disease
Impaired liver function	<ul style="list-style-type: none">• Elevated blood concentrations of liver transaminases to twice normal concentration
Pulmonary edema	
Cerebral or visual symptoms	

* Each measured as mg/dL.

Severe Features of Preeclampsia

BOX E-1. Severe Features of Preeclampsia (Any of these findings) ↵

- Systolic blood pressure of **160 mm Hg** or higher, or diastolic blood pressure of **110 mm Hg** or higher on two occasions at least 4 hours apart while the patient is on bed rest (unless antihypertensive therapy is initiated before this time)
- Thrombocytopenia (**platelet count less than 100,000/microliter**)
- Impaired liver function as indicated by abnormally elevated blood concentrations of **liver enzymes** (to twice normal concentration), severe persistent right upper quadrant or epigastric pain unresponsive to medication and not accounted for by alternative diagnoses, or both
- Progressive renal insufficiency (**serum creatinine concentration greater than 1.1 mg/dL or a doubling of the serum creatinine concentration in the absence of other renal disease**)
- Pulmonary edema
- New-onset cerebral or visual disturbances



The American College of
Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

COMMITTEE OPINION

Number 623 • February 2015 (*Replaces Committee Opinion Number 514, December 2011*)

Committee on Obstetric Practice

This document reflects emerging clinical and scientific advances as of the date issued and is subject to change. The information should not be construed as dictating an exclusive course of treatment or procedure to be followed.

Emergent Therapy for Acute-Onset, Severe Hypertension During Pregnancy and the Postpartum Period

Antihypertensive Medications

SBP \geq 160 OR DBP \geq 105-110?

- Medications should be given NO MORE than 1 hour after presenting in hypertensive emergency*
 - Aim for no more than 30 minutes
- This is the biggest step in decreasing morbidity and mortality
- Aim to return BP to a range where intracranial hemorrhage not a risk, but not to normal range
 - Goal: 140-160/90-100

*Hypertensive emergency: acute-onset, severe hypertension that persists for \geq 15 minutes

Anihypertensive Medications

First Line Agents

	IV Labetalol	IV Hydralizine
Dose (IVP over 2 minutes)	20 mg	5-10 mg
Onset	2-5 minutes	5-20 minutes
Peak	5 minutes	15-30 minutes
24 hour max	220 mg	25 mg

**** If no IV access, PO nifedipine should be used**

- Nifedipine PO 10 mg may repeat in 30 min
- Onset: 5-20 min
- Peak 30-60 min

Maternal Early Warning Criteria

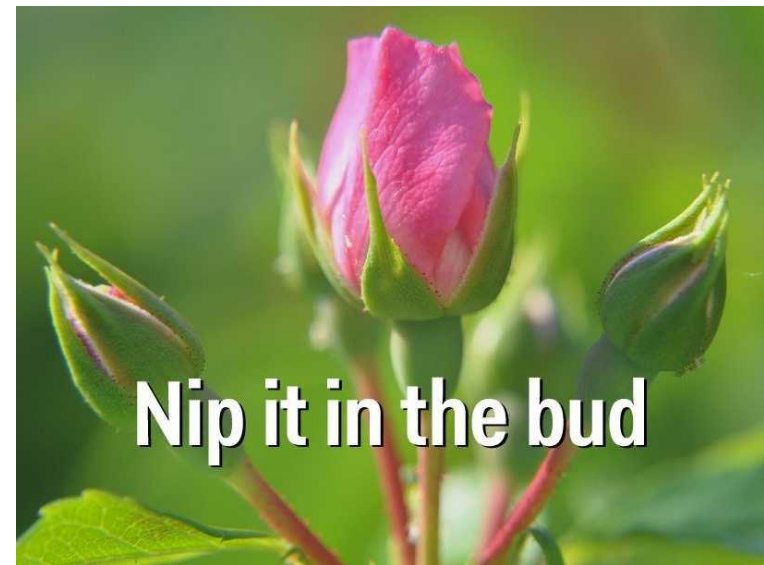
The Maternal Early Warning Criteria	
Measure	Value
Systolic Blood Pressure (mm Hg)	<90 or >160
Diastolic Blood Pressure (mm Hg)	>100
Heart rate (beats per minute)	<50 or >120
Respiratory rate (breaths per min)	<10 or >30
Oxygen saturation on room air, at sea level %	<95
Oliguria, mL/hr for ≥ 2 hrs	<35
Maternal agitation, confusion, or unresponsiveness	
Woman with preeclampsia reporting a non-remitting headache or shortness of breath	

The Maternal Early Warning Criteria: A Proposal From the National Partnership for Maternal Safety.

Mhyre, Jill; D'Oria, Robyn; MA, RNC; Hameed, Afshan; Lappen, Justin; Holley, Sharon; CNM, DPN; Hunter, Stephen; MD, PhD; Jones, Robin; King, Jeffrey; Dalton, Mary

Maternal Early Warning Systems

- Abnormal physiologic signs and symptoms precede critical illness
- Early intervention will avoid severe M&M occurrence
- Effective policy of escalation of care





What about this position?

“Her blood pressure was elevated when she first presented to triage but I had her rest on her side to cycle her blood pressures and all other measurements have been within normal limits”





PATIENT SAFETY BUNDLE

READINESS

Every Unit

- Standards for early warning signs, diagnostic criteria, monitoring and treatment of severe preeclampsia/eclampsia (include order sets and algorithms)
- Unit education on protocols, unit-based drills (with post-drill debriefs)
- Process for timely triage and evaluation of pregnant and postpartum women with hypertension including ED and outpatient areas
- Rapid access to medications used for severe hypertension/eclampsia: Medications should be stocked and immediately available on L&D and in other areas where patients may be treated. Include brief guide for administration and dosage.
- System plan for escalation, obtaining appropriate consultation, and maternal transport, as needed

RECOGNITION & PREVENTION

Every Patient

- Standard protocol for measurement and assessment of BP and urine protein for all pregnant and postpartum women
- Standard response to maternal early warning signs including listening to and investigating patient symptoms and assessment of labs (e.g. CBC with platelets, AST and ALT)
- Facility-wide standards for educating prenatal and postpartum women on signs and symptoms of hypertension and preeclampsia

Hypertension



RESPONSE

Every case of severe hypertension/preeclampsia

- Facility-wide standard protocols with checklists and escalation policies for management and treatment of:
 - Severe hypertension
 - Eclampsia, seizure prophylaxis, and magnesium over-dosage
 - Postpartum presentation of severe hypertension/preeclampsia
- Minimum requirements for protocol:
 - Notification of physician or primary care provider if systolic BP \geq 160 or diastolic BP \geq 110 for two measurements within 15 minutes
 - After the second elevated reading, treatment should be initiated ASAP (preferably within 60 minutes of verification)
 - Includes onset and duration of magnesium sulfate therapy
 - Includes escalation measures for those unresponsive to standard treatment
 - Describes manner and verification of follow-up within 7 to 14 days postpartum
 - Describe postpartum patient education for women with preeclampsia
- Support plan for patients, families, and staff for ICU admissions and serious complications of severe hypertension

REPORTING/SYSTEMS LEARNING

Every unit

- Establish a culture of huddles for high risk patients and post-event debriefs to identify successes and opportunities
- Multidisciplinary review of all severe hypertension/eclampsia cases admitted to ICU for systems issues
- Monitor outcomes and process metrics

Note: "Facility-wide" indicates all areas where pregnant or postpartum women receive care. (E.g. L&D, postpartum critical care, emergency department, and others depending on the facility).

Hypertension



Rule Out Preeclampsia

- Clean catch urine → 24 hr urine protein collection
- BP Q 10 minutes
- NST X 30 minutes or longer
- Labs-CBC, Plts, AST, Protein /Creatinine ratio
- Ask pt about changes in vision, epigastric pain, or headache
- Note swelling, DTR's

The Importance of Interdepartmental Collaboration and Safe Triage for Pregnant Women in the Emergency Department

Chagolla, B et al. (2013) JOGNN

■ Population changes

- **Diabetes**
- **Hypertension**
- **Obesity**
- **No prenatal care**

The Importance of Interdepartmental Collaboration and Safe Triage for Pregnant Women in the Emergency Department

Chagolla, B., et al. (2013) JOGNN

- 30 Dignity Health Hospitals
- Describes a triage model for evaluation of pregnant women in the ER
- Standardize Care
- Clear policies and procedures
- Interdepartmental communication
- UCSF case

HOSPITAL TRIAGE

- ✓ STAFFING
- ✓ ASSESSMENT
- ✓ GUIDELINES

Hospital Triage: Assessments & Interventions

Initially

- Maternal VS, FHR, and UC's



Further Evaluation

- Vaginal bleeding
- Acute pain
- Fever
- Preterm
- Hypertension
- Indeterminate or abnormal FHR tracing

If these findings are present the responsible obstetric-care **provider** should be promptly informed

Hospital Triage:

Common Scenarios

- Decreased Fetal movement
- Rule Out Labor
- Rule Out Abruptio (s/p MVA)
- Rule Out Preeclampsia
- Rule Out Premature rupture of Membranes
- Rule Out SAB or Ectopic
- Rule Out Hyperemesis
- Sexually Transmitted Disease
- Urinary Tract Infection
- Asthma
- Version
- Amniocentesis
- Wound Checks

Clinical Presentation:

Generalized Broad Complaints

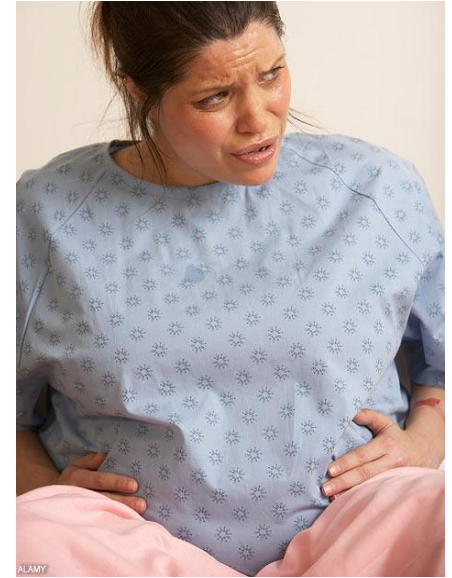
- Pain
 - Abdominal
 - Epigastric
 - Broad Ligament
 - Back
 - Headache
- Gastrointestinal
 - Vomiting
 - Nausea
 - Diarrhea
- Respiratory
 - Shortness of Breath

One of the most difficult aspects of OB Triage is managing conflicting symptomatology

- **History**
- **Physical Assessment**
- **Lab results**
- **U/S**
- **CT**
- **MRI**

Initial Assessment of Preterm Labor

- Health history -suspicion
- Reproductive history – be careful
- Appropriate physical exam (Targeted) - VS
- Prenatal course of current pregnancy (record)
- Determine accurate gestational age
- Routine obstetric clinical parameters
- Describe signs/symptoms of PTL
- Education of woman and support system



Hospital Triage:

Preterm Labor

Assessments & Interventions

Concise MD order set: Tocolysis, Neuroprotection

- Clean catch urine specimen
- HOB ↑ 20-30 degrees - lateral decubitus position
- Vital Signs and current weight
- Obtain History
- Assess hydration status
- EFM monitoring / fetal assessment: notify Peds
- Sterile Speculum procedure: notify MFM
 - GBS Procedure
 - Fetal fibronectin
 - Amnisure™ testing
- Vaginal U/S → cervical length
- Betamethasone
- Nursing Competencies
 - Sterile speculum exam
 - Amnisure™ testing
 - Fern testing



Perivable Birth: 20_{+0/7} - 25_{+6/7}

extreme preterm, micro preemie, threshold of viability



- survival rates in general (variance)
 - 0% @ 20 weeks
 - 50% @ 25 weeks
- An overview of survival and morbidity
- The possibility of long-term neurological and neurodevelopmental problems
- The possibility that expectations for the baby may change after birth depending on the condition of the newborn

In general, tocolytics are not indicated for use before neonatal viability and no data exists regarding the efficacy of corticosteroid use before viability

ACOG Practice Bulletin Number 171 October 2016

Perlman J. Perivable birth: executive summary Obstet Gynecol. 2014; 124(3):635)

ACOG & SMFA; Ecker JL. Et al., Perivable birth: interim update. Am J Ob Gyn. 2016;215(2): B2.e1-B12.el.

OB Trauma s/p MVA: Rhogram? KB?

Rule Out Abruptio

- **If vaginal bleeding**

- NST/toco

- Place IV

- Labs: CBC, T&S, PT/PTT

- **If Ø vaginal bleeding**

- NST/toco

- Place IV

- Labs: CBC, T&S, PT/PTT

- **Minimum 4-6 hrs observation**

Angelini et al., (2005) Journal of Midwifery and Women's Health

ACOG educational bulletin. Obstetric aspects of trauma management. Number 251

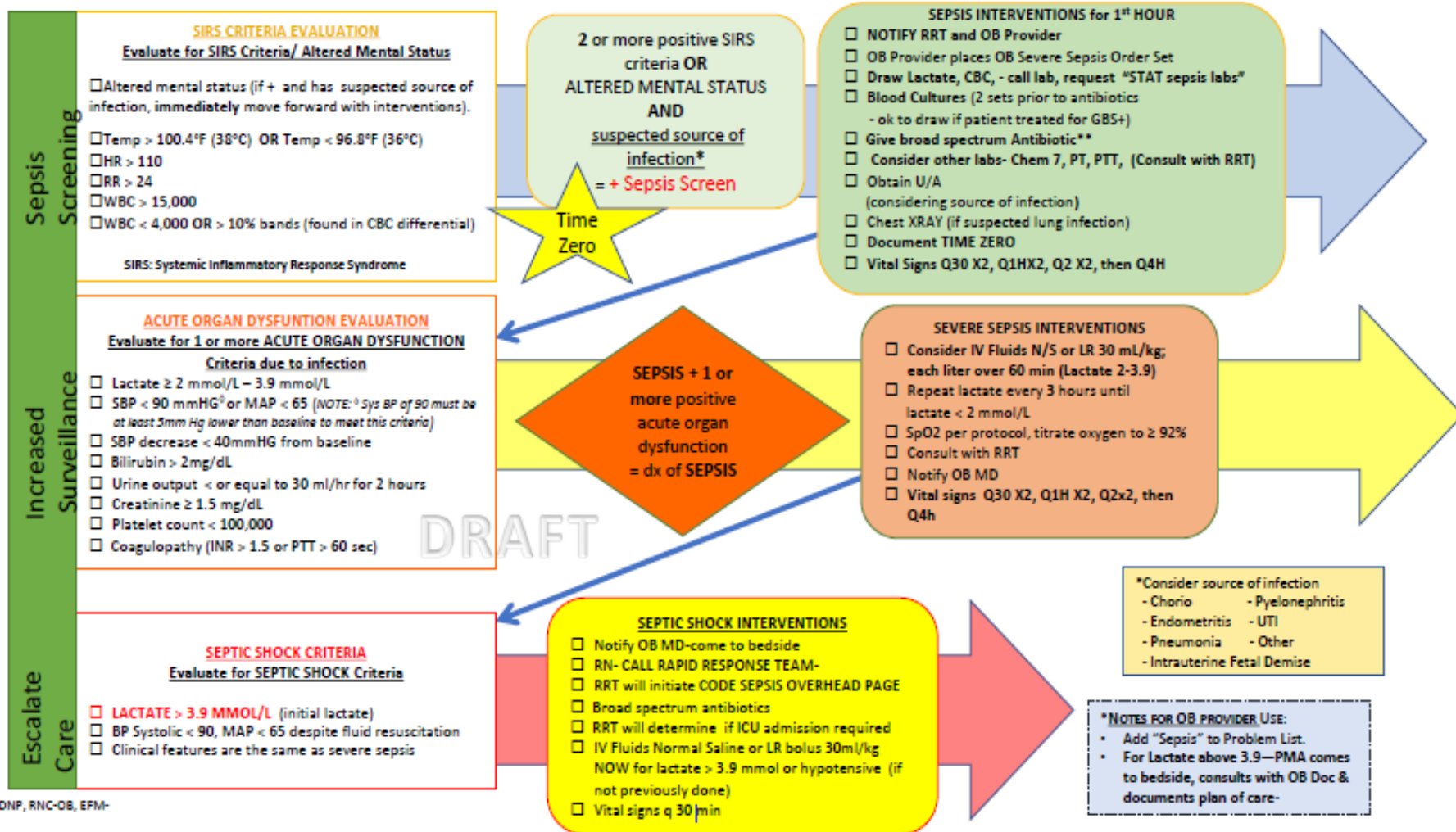
Document, Document, Document

- ALL information needs to be placed somewhere on a written or computerized chart.
 - Lab results
 - Fetal test results
 - Fetal status
 - Conversations with consultants – recommendations
 - Interventions performed
 - Plan of care
 - Follow-up plans
 - Instructions – verbal, written
 - Patient understanding

Maternal Sepsis Pathway-2019

Screen in triage, upon admission, every shift (within first 2 hours of shift) and PRN suspected infection

Document in OB Sepsis Summary Flowsheet.



Lori Olvera DNP, RNC-OB, EFM-

Developing a OB Triage Tool

Paisley, et al., 2011 MCN

- Committee was formed in 2007 to explore
 - how obstetric triage was occurring
 - develop a better triage process
- Committee members included
 - triage nurses, perinatal educators, nurse managers, risk managers, nursing administrators.
- 4 Hospital sites were observed and evaluated for their triage process and practice. The following inconsistencies were identified:

Nurses cared for women in order of arrival, rather than by triage acuity.

The time the patient's first encounter with a triage

- nurse should be used as the time the acuity is assigned;



UCSF Benioff Children's Hospitals

- no current valid and reliable obstetric triage tools were found

Florida Hospital OB Triage Acuity Tool©

- Based on Manchester Triage Group
 - a five-tier system as a evolution over time
- Canadian ED Triage and Acuity Scale
 - includes time frames and acuity levels
 - first by nurses, then by the physician

Florida Hospital OB Triage Acuity Tool©

Patient should have Primary OB triage assessment within 10 minutes of arrival.

1 - Immediate

2 – Urgent (Within 15 minutes)

3 – Semi Urgent (30 minutes)

• 4 – Less Urgent (60 minutes)

• Procedure/ Testing (≤ 120 min)

Florida Hospital OB Triage Acuity Tool©

Patient should have Primary OB triage assessment within 10 minutes of arrival.

1 - Immediate

- Airway,
 - Breathing,
 - Circulation
- } **Resuscitative**
- Respiratory Distress
 - Chest pain
 - Trauma
 - Hemorrhage
 - Presenting fetal parts
 - Prolapsed umbilical cord
 - Impending Delivery
 - Seizing

2 – Urgent (*Within 15 min)

- R/O LABOR
 - Active labor
 - Regular contractions
 - ≤ 5 mins apart
 - Severe pain (≥7 on scale)
- PRETERM (20–30 6/7 weeks)
 - Backache, Contractions, Tightening “Cramping”
 - Spotting, Rupture of Membranes (R/O ROM)
 - UTI symptoms
- VAGINAL DISCHARGE
 - Heavy blood loss, Passing clots
- FETAL WELL-BEING
 - No fetal movement, Decelerations
- BLOOD PRESSURE
 - Severe preeclampsia, Epigastric pain,
 - Blurred vision, Severe Headache, Elevated BP
- MENTAL/PSYCHOSOCIAL
 - Altered conscious level, Suicidal
- OTHER FACTORS
 - History of seizure (within 6 hrs), Alert on arrival
 - Diabetes, Hypoglycemia/ Hyperglycemia
 - Severe Pain (≥7 on scale)

Florida Hospital OB Triage Acuity Tool©

Patient should have Primary OB triage assessment within 10 minutes of arrival.

3 – Semi Urgent (30 min)

- R/O LABOR
 - Irregular contractions
 - >37 weeks
 - Moderate pain
 - (4–6) on scale)
- VAGINAL DISCHARGE
 - Spotting” >37 weeks, SRM > 37wks
- FETAL WELL-BEING
 - ↓ Fetal Movement,
 - Non-reactive Non-stress Test (NST)
- BLOOD PRESSURE
 - BP checks
 - History of high BP
- MENTAL/PSYCHOSOCIAL
 - History of suicide attempts
- OTHER FACTORS
 - Previous Cesarean in Labor
 - Recent trauma, Falls, MVA
 - Fever/chills, Active Vomiting
 - Moderate Pain (4–6 on scale)

4 – Less Urgent (60 min)

- R/O LABOR
 - Early labor, Mild irregular contractions
 - Backache > 37 weeks
 - Mild pain (1–3 on scale)
- VAGINAL DISCHARGE
 - Bloody show
 - Mucus
 - R/o infection
- MENTAL/PSYCHOSOCIAL
 - Non-OB Complaints
 - Insomnia
 - Psychosocial problems
 - not “acting out”
- OTHER FACTORS
 - Aches and pains
 - Nausea
 - Hyperemesis
 - Mild Pain (1–3 on scale)

Florida Hospital OB Triage Acuity Tool©

Patient should have Primary OB triage assessment within 10 minutes of arrival.

Procedure/ Testing (≤ 120 min)

- FETAL WELL-BEING
 - Scheduled NST
 - Biophysical Profile
 - Ultrasound
- OTHER FACTORS
 - Elective/scheduled
 - Cesarean birth
 - Inductions
 - Other procedures
 - Incision check
 - Breech version
 - Injections
 - Betamethasone

Florida Hospital OB Triage Patient Flow Process

Ambulatory/Ambulance Arrival

PRIMARY OB TRIAGE

Initial contact with the patient to determine acuity. It includes:
Name, Physician, Gravida/Parity, Gestational Age, Medical and Obstetrical history, Chief Complaint and Pain Assessment.

IMMEDIATE TREATMENT/DELIVERY

MEDICAL SCREENING EXAM

Complete "Objective Focused Assessment"

DISPOSITION

Admit

Observe

Discharge

SECONDARY OB TRIAGE

Periodic Reassessment to be done within the time frame set for that acuity. It includes Maternal Vital Signs, Fetal Heart Tones, Pain reassessment and question "Any changes in condition/chief complaint?"

Barriers Identified

- The triage committee continues to meet, review data, and identify barriers

Barriers include:

More than 2 triage patients per triage nurse

Waiting for tests to be performed/results

Multiple patients arriving at once

Triage staff being assigned to other duties

Resolution of Barriers

Ensure adequate nurse staffing

Work with ancillary departments to speed the process of obtaining results

Implementing an Obstetric triage acuity scale: interrater reliability and patient flow analysis

Smithson, D. et al. AJOG (2013)

- Developed a 5 category Obstetric triage acuity scale (OTAS)
- Explore the possibility of “Fast track”
- Practice change for nurse
 - Avoid informal triage assessment
 - Need to set target times
- **Speculate** implementation of OTAS will:
 - **Decrease LOS** for low acuity cases
 - **Improve secondary assessment** by MD for higher acuity cases

Implementing an Obstetric triage acuity scale: interrater reliability and patient flow analysis

OTAS	Level 1 (Resuscitative)	Level 2 (Emergent)	Level 3 (Urgent)	Level 4 (Less Urgent)	Level 5 (Non-Urgent)
Time to Secondary Health Care Provider	Immediate	≤ 15 minutes	≤ 30 minutes	≤ 60 minutes	≤ 120 minutes (2 hours)
Re-assessment	Continuous Nursing Care	Every 15 minutes	Every 15 minutes	Every 30 minutes	Every 60 minutes
Labour/Fluid	▪ Imminent birth	▪ Suspected preterm labour/PPROM < 37 weeks	▪ Signs of active labour > 37 weeks	▪ Signs of early labour/SROM > 37 weeks	▪ Discomforts of pregnancy
Bleeding	▪ Active vaginal bleeding with/without abdominal pain	▪ Bleeding associated with cramping (> spotting) < 37 weeks	▪ Bleeding associated with cramping (> spotting) > 37 weeks	▪ Spotting	
Hypertension	▪ Seizure activity	▪ Hypertension > 160/110 and/or headache, visual disturbance, RUQ pain	▪ Mild Hypertension > 140/90 with/without associated signs and symptoms		
Fetal Assessment	▪ Abnormal FHR tracing ▪ No fetal movement	▪ Atypical FHR tracing, abnormal BPP, abnormal dopplers ▪ Decreased fetal movement			
Other	▪ Acute onset severe abdominal pain ▪ Altered level of consciousness ▪ Cord prolapse ▪ Severe respiratory distress ▪ Suspected sepsis	▪ Major trauma ▪ Shortness of breath ▪ Unplanned and unattended birth	▪ Abdominal/back pain greater than expected in pregnancy ▪ Flank pain/hematuria ▪ Nausea/vomiting and/or diarrhea with suspected dehydration	▪ Ongoing assessment from outpatient clinic (for hypertension, blood work) ▪ Minor trauma (minor MVC/fall) ▪ Nausea/vomiting and/or diarrhea ▪ Signs of infection (ie. dysuria, cough, fever, chills)	▪ Anything that does not seem to pose threat to mother or fetus ▪ Cervical Ripening ▪ Outpatient placenta previa protocol ▪ Pre-booked visits (ie. Rh and progesterone injections, NST) ▪ Assessment for version ▪ Rashes

Obstetric Triage: Staffing

- Multiply 1.2 - 1.5 of overall birth volume
- Requires assessment of mother and fetus
 - “in a timely manner” -not defined by AAP or ACOG
- Care is ongoing until disposition
- The initial triage process (10 - 20) minutes
- Requires 1 nurse to 1 woman presenting for care
- This ratio may be changed to 1 Nurse: 2-3 woman as maternal-fetal status is determined to be stable or until patient disposition is determined
- 1 Nurse to 2-3 women during non-stress testing

Question:

You have a patient in Triage for a scheduled NST who you just put on the monitor. A new patient arrives and is complaining of not feeling well/headache/maybe has the flu. She's not feeling any painful contractions and isn't due for 6 weeks. You check VS: Temp 100.5, HR 118, BP 162/98

What should you do next?

- A. Ask her if she can go to the bathroom and give a urine sample
- B. Apply FHR Monitor, wait 10 minutes and assess fetal tracing
- C. Notify the Obstetrician and request immediate bedside evaluation
- D. Call out to the desk for an extra pair of hands
- E. C & D

Perinatal Acuity Tool Simpson, Kathleen; Rice PhD, RNC

Acuity Level	Nurse-to-Patient Ratio	Type of Patient or Clinical Situation
A	2-to-1	Critically ill, hemodynamically unstable
B	2-to-2	Birth (including 30–60 min during the immediate postpartum recovery period until the critical elements are met for both mother and baby)
C	1-to-1	Epidural initiation (approximately 30 min); oxytocin induction or augmentation of labor; magnesium sulfate during labor and immediate postpartum; second-stage labor pushing; some indeterminate and all abnormal fetal heart rate patterns; labor in the shower or whirlpool tub (if support person is not available to stay with patient); intermittent auscultation during active labor; morbid obesity such that continuous electronic fetal monitoring is challenging requiring repeated bedside monitoring adjustments
D	1-to-2	Cervical ripening with pharmacologic agents; spontaneous labor with adequate pain control without pharmacologic agents, or labor epidural or parenteral pain relief resulting in patient comfort
E	1-to-3	Obstetric triage, rule out labor, nonstress testing, stable antepartum patients, and mother–baby couplets



MCN, American Journal of Maternal Child Nursing. 38(3):191, May/June 2013.

USF Benioff Children's Hospitals



The American College of
Obstetricians and Gynecologists

- WOMEN'S HEALTH CARE PHYSICIANS

Obstetrics & Gynecology
VOL. 123, NO. 5, MAY 2014

Current Commentary

The National Partnership for Maternal Safety

Mary E. D'Alton, MD, Elliott K. Main, MD, M. Kathryn Menard, MD, and Barbara S. Levy, MD

Obstetrics & Gynecology
VOL. 124, NO. 4, Oct 2014

Current Commentary

The Maternal Early Warning Criteria

A Proposal From the National Partnership for Maternal Safety

Mhyre, J., D' Oria, R., Hameed, A., et al

YOUR PRACTICE DOMAIN

- Stress
 - Fatigue
 - High stakes
 - Time pressure
 - Task saturation
 - Auditory overload
- Two patients
 - Language barrier
 - High expectations
 - Limited resources
 - Multiple care teams
 - Frantic spouse/family

■ Sentinel Event Analysis

■ Root Causes

- ◎ Communication (72%)
- ◎ Staff competency (47%)
- ◎ Orientation and training (40%)
- ◎ Inadequate fetal monitoring (34%)
- ◎ Unavailable monitoring equipment/drugs (30%)
- ◎ Credentialing/Privileging/Supervising MD CNM (30%)
- ◎ Staffing issues (25%)
- ◎ Physician unavailable or delayed (19%)
- ◎ Unavailable prenatal information (11%)

The Principles of the Program Behavioral Skills (CRM)

- Know your environment
- Anticipate and plan
- Assume the leadership role
- Communicate effectively
- Distribute work load optimally
- Allocate attention Wisely
- Utilize all available information
- Utilize all available resources
- Call for help early enough
- Maintain professional behavior

Know Your Environment

- Sounds simple but it's not !
- Emergency equipment rarely used
 - Portable cardiac monitor, Central Line set-up
- Often there was a small widget needed
 - Suction failure, pentothal pin, stopcock
- Equipment and supplies move
- Staff vacations, relief/ float staff

UCSF Environment: To improve staff's access to equipment & supplies

Joni Gonzalez, RN, BSN

- The Gallup Pole Survey (given to UC staff) asked the question:
 - “I have the materials and equipment I need to do my work right.”
- Our score on 15L was 3.32 out of 5.0
 - The average score for BCH was 3.68
 - UC Med Center was 3.78
 - Overall UC system was 3.68
- 15L staff meeting identified this as an area for improvement. Staff volunteered to help form a committee to improve 15L's work environment
- I volunteered to Chair the committee to address these issues
- The “*Staff Engagement Council-Workflow Committee*” was created

Mission

To improve workflow on the unit for staff to feel they have what they need to do their job— in essence to improve patient safety and staff's job satisfaction.

Patient Safety

Work Environment

Staff Satisfaction

Instrument & Supply Room

Access to Emergency Instruments

Relocated non-emergent equipment

Unobstructed path to emergency instruments

Reestablished **par levels**

Emergency instruments/**Red Bins**



Instrument & Supply Room

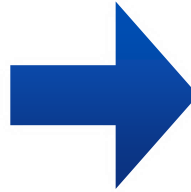
Access to Emergency Supplies

- Rearranged supplies and labeled bins
- Stocked **Emergency supplies in red bins** & moved to upper shelves
- Re-labeled frequent use bins with known names
- Grouped related items



Labor Antepartum & Triage

Monitor Carts



- **Monitor parts** easily accessible and visible
- **Drawer Organization**



Triage Supply Carts & Caddies

Supplies to Improve Triage Workflow

- Wound care caddies & Specimen cup
- Mayo Stand Carts - Supplies needed for SVE exams
- Decreases Patient waiting time in triage for the Exam Room
- Portable Supplies Carts - Accommodate our inpatient Antepartum population



Tools to Improve Triage Workflow

-
- Detailed Daily Checklist**
- "L (1-4): Room"**
- ☐ Labor Cart
 - ☐ N pole & pump- plugged in
 - ☐ Crib
- "Hill Room"**
- ☐ Ambu-Bag
 - ☐ Suction
 - ☐ Bulb Syringe
 - ☐ Cord Clamp
 - ☐ 2x- laryngoscope handle
 - ☐ 2x- size 0 blade
 - ☐ 2x- size 1 blade
 - ☐ 2x- Et tubes- 2.5, 3.0, 3.5
 - ☐ 2x- Sylet
 - ☐ 2x- Yellow and white meconium aspirator
 - ☐ 2x- suction catheter- 8fr & 10fr
 - ☐ 2x- Intermittent masks- green & blue
 - ☐ 2x- skin temperature sensors
 - ☐ 1x- scissors
- "Med Room"**
- ☐ EFM, Toco,
 - ☐ O2 sat sensor, BP cuffs
 - ☐ 2x- PSE, IFM cable
 - ☐ 2x- Amnio hook
 - ☐ Mineral Oil, Lubricant jelly, Gloves
 - ☐ IUPC
 - ☐ Selly Bands, Straps
- "Cabinet"**
- ☐ Medication box, 1ml TB syringe
 - ☐ Light wand
- "Triage 1/2"**
- "Triage 3/4"**
- Exam Room**
- Med Room**
- OR1 Set Up**
- OR1 Hill-Rom**
- OR1 Cabinet**
- OR1 SCD**
- OR2 Set Up**
- OR2 Hill-Rom**
- OR2 Cabinet**
- OR2 SCD**

Detailed Daily Checklist


"L (2-4) Room"

- ☐ Labor Cart
- ☐ IV pole & pump- plugged in
- ☐ Crib

"Kit-Room"

- ☐ Ambu-Bag
- ☐ Suction
- ☐ Bulb Syringe
- ☐ Cord Clamp
- ☐ 2x- laryngoscope handle
- ☐ 2x- size D blade
- ☐ 2x- size I blade
- ☐ 2x- Et tubes- 2.5, 3.0, 3.5
- ☐ 2x- Stylet
- ☐ 2x- Yellow and white meconium aspirator
- ☐ 2x- suction catheter- 8fr & 10fr
- ☐ 2x- Infant mask- green & blue
- ☐ 2x- skin temperature sensors
- ☐ 1x- scissors

"Monitor"

- ☐ EFM, Toc, 
- ☐ OI sat sensor, 9P cuffs
- ☐ 2x- FM, IMF cable
- ☐ 2x- Amnio hook
- ☐ Mineral Oil, Lubricant Jelly, Gloves
- ☐ HUPC
- ☐ Belly Bands, Straps

"Cabinet"

- ☐ Medication box, 1ml TB syringe
- ☐ Light wand
- ☐ Footprint materials & name cards
- ☐ Ambu-bag (adult)
- ☐ Knel (suction)

"Triage/2/3/4; Exam Room"

- ☐ Urine cups
- ☐ Belly bands & Straps
- ☐ IV start- kit
- ☐ Ong Kit & Sterile speculums
- ☐ Linenbroth (also kept in the dirty utility fridge)
- ☐ Nitrassive Paper
- ☐ Linens

"Med Room"

- ☐ SCD pumps, tubing, & sleeves
- ☐ IV pumps & channels
- ☐ Glucometers & casset
- ☐ IV start-kit

"OR (1, 2) Set up"

- ☐ C/S cart
- ☐ Lap counter
- ☐ Warmers

"OR Kit-Room" same as explained above

"OR Cabinets"

- ☐ Vacuum & vacuum handle
- ☐ Gloves (latex & non-latex)
- ☐ Forceps
- ☐ Placenta container
- ☐ Silverlon dressings

Anticipate and Plan for Crisis

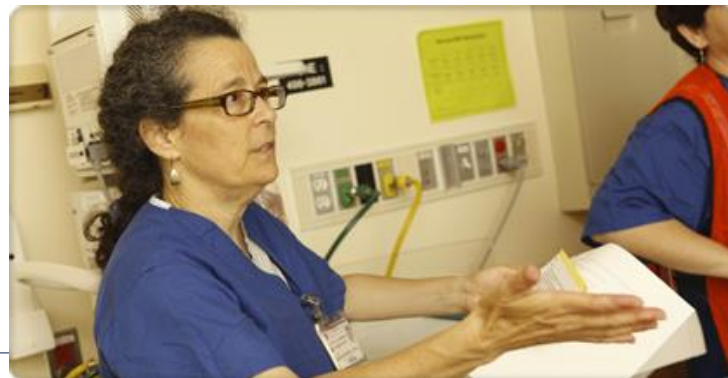
- Situational Awareness
- Don't sleep on the job – Risk assess
- Know the department standards and guidelines
- Have a back up plan for your back up plan

Assume the Leadership Role

- The Primary Nurse



- What happens when the MD enters the scenario?



Communicate Effectively

- Again this sounds so simple
- How exactly does one learn to communicate effectively?
- Are there tools/ strategies to promote effective communication?
- Communication is revealed on the video
 - Masks
 - Alarms
 - Incoming staff

Distribute Work Load Optimally

- Avoid the “one woman band”
 - IV start
 - EMR intake
 - Notify staff

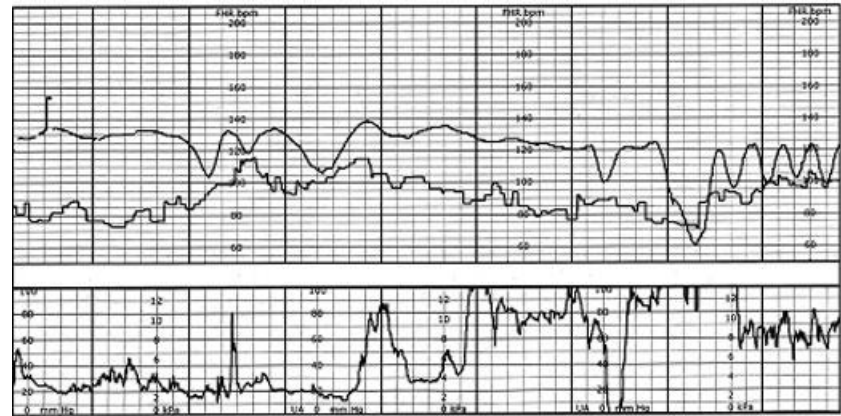
- Utilize staff in the area of expertise
 - Respiratory Therapists – blood gas analysis
 - Nursing Supervisor - recorder



Allocate Attention Wisely

■ Finding Twin B

- Time sensitive
- Avoid **fixation** errors



- Avoid flitting
- Finish assigned tasks



Utilize all Available Information

- Lost in Translation
 - Prenatal record
 - Patient hand-offs
 - Nurse to Nurse report
 - Patient transfer

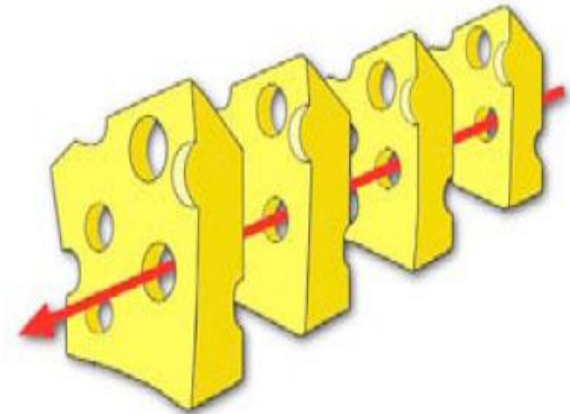


Figure 2. Reason's Swiss cheese model

- Utilization Strategies
 - Sharing a mental model
 - Thinking out loud

Maintain professional behavior

- Laughing
- Offensive language



Call for Help Early

- What is the **culture** - is it safe?
- Every hospital system is **unique**
 - How exactly does the staff call for help?
 - Variations on shifts and weekends
- What language is used to convey urgency
 - Code OB, Code Red, Code H, OB Stat....
 - Ensure the staff knows what/how when to call
- Huddles



Promote High Reliability

- By conducting a drill you can **actually test** your department's capability to handle a rare obstetrical triage emergency
- **Measure in minutes**
 - Immediate bedside evaluation
 - Rapid response team
 - Stat lab turn around time
 - Expert consultation
 - PRBC's transfusing after request
 - Time of birth after prolapse cord
 - Magnesium Sulfate bolus infusing

Ability to Debrief



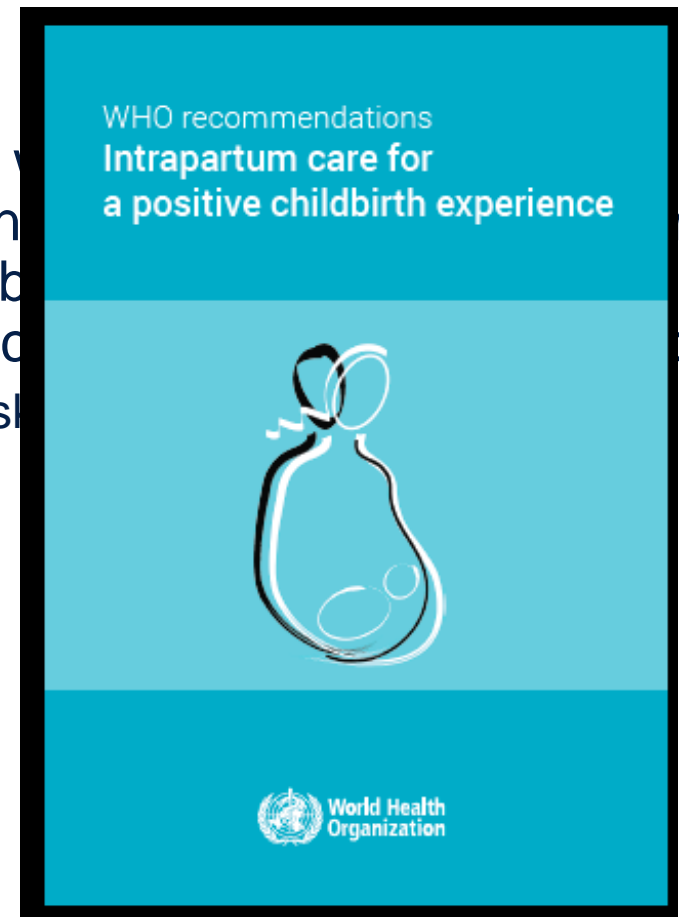
- Rarely is there a record of events & actions
- Rarely is there any systematic debriefing afterwards
- So...how does the team learn for next time?

Case Presentation

Date/Time	Documentation: assessment, vital signs, medication. etc	Notes
5/5/18	40 yo G6P5 BIBA MB Peds ED c/o vomiting blood stated and appeared pregnant Medical Hx: Atrial Fibrillation, Congenital heart disease, Pulmonary Embolism Delusional psychiatric disorder	

3.1 Care throughout labour and birth

- Care organized for and provided to all women maintains their dignity, privacy and control, protects them from harm and mistreatment, and enables them to receive continuous support during labour and delivery
 - Training of interpersonal communication skills
 - Monitoring disrespect and abuse
 - Staff mentorship
 - Improving staff conditions
 - Develop a policy to promote RMC



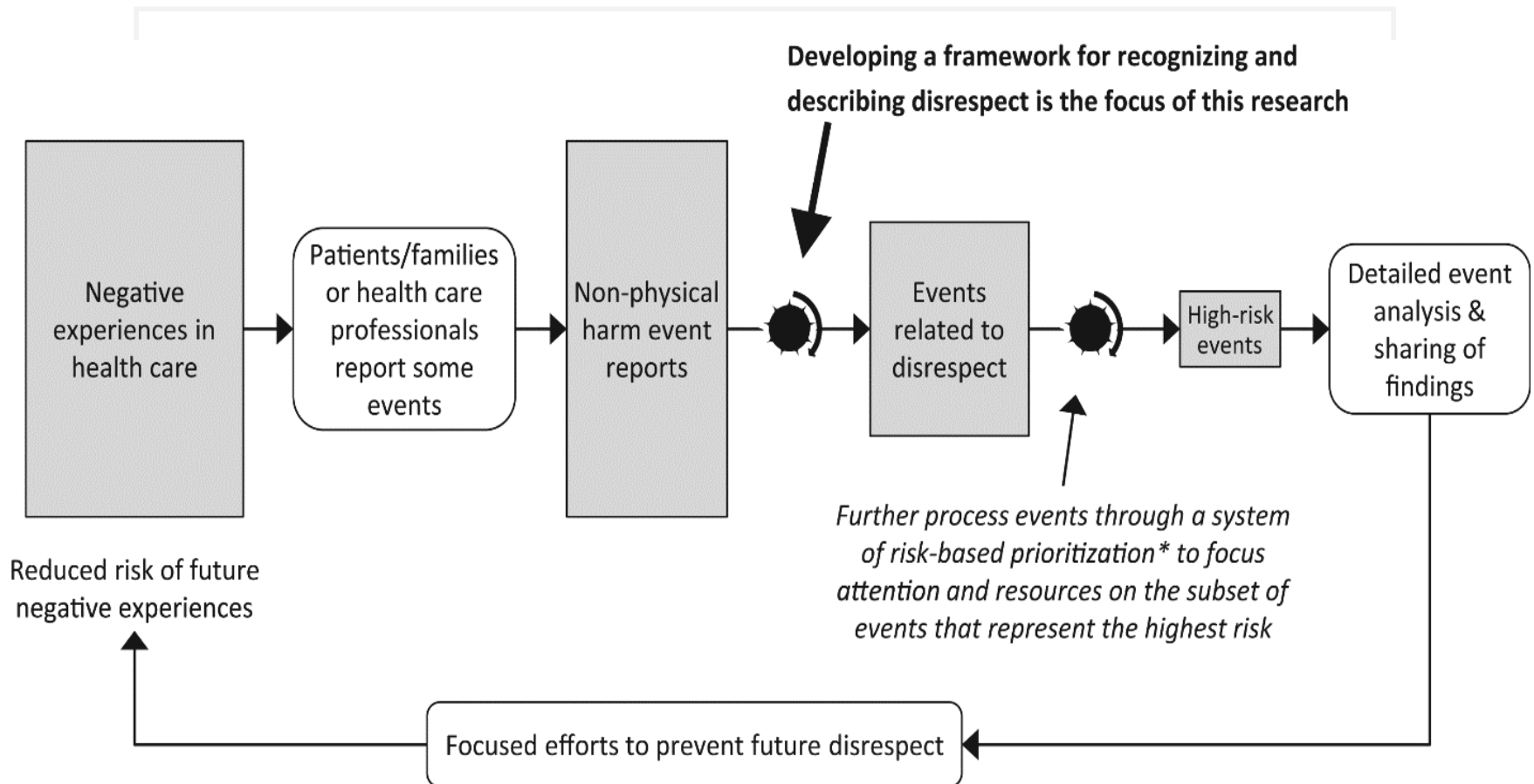
Consensus Bundle on Maternal Mental Health

- Kendig, S., et. Al., (2017). Consensus Bundle on Maternal Mental Health: Perinatal Depression and Anxiety. JOGNN, 46(2), 272-281.

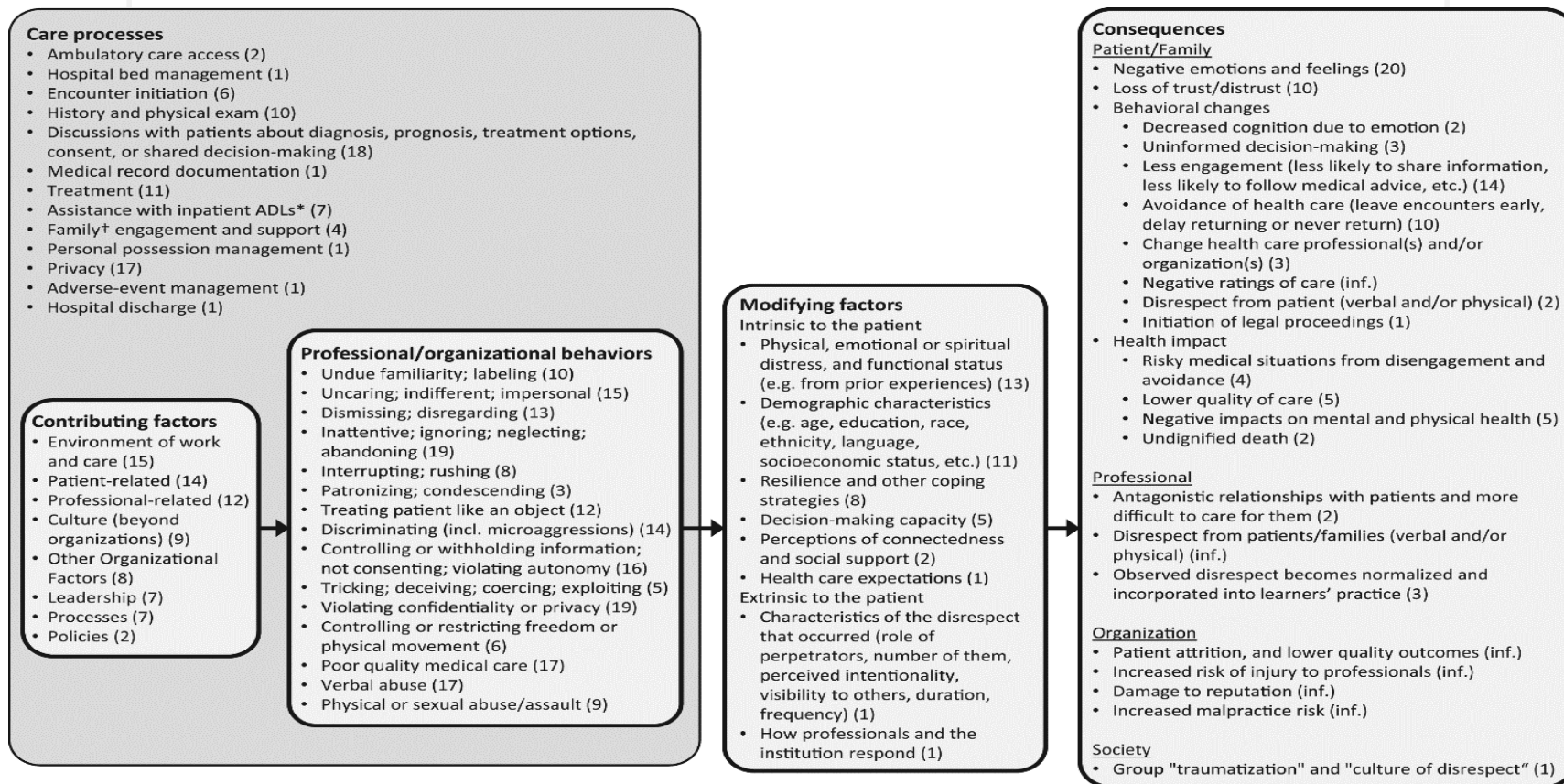


Eliminate Disrespect

- A Road Map for Advancing the Practice of Respect in Health Care: The Results of an Interdisciplinary Modified Delphi Consensus Study.
 - Sokol Hessner, L., et.al. (2018). The joint commission journal on quality and patient safety, 44(8), 463-476.
-
- Leaders must champion a culture of respect and dignity
 - Share responsibility (Multidisciplinary) that promotes accountability
 - Engage and support health care work force
 - Partner with Patients and Families
-
- Establish a system to learn and improve the practice of respect



From: Development of a framework to describe patient and family harm from disrespect and promote improvements in quality and safety: a scoping review. *Int J Qual Health Care*. Published online November 14, 2018. doi:10.1093/intqhc/mzy231
Int J Qual Health Care | © The Author(s) 2018. Published by Oxford University Press in association with the International Society for Quality in Health Care.



From: Development of a framework to describe patient and family harm from disrespect and promote improvements in quality and safety: a scoping review. *Int J Qual Health Care*. Published online November 14, 2018. doi:10.1093/intqhc/mzy231

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Office of Origin: Environment of Care

I. PURPOSE AND SCOPE

To provide guidelines for the multifaceted Workplace Violence Prevention (WVP) Program that covers all patient care clinics, units, services, and operations under the licenses of UCSF Medical Center, UCSF Benioff Children's Hospital San Francisco, and UCSF Langley Porter Psychiatric Hospital and Clinics. As part of Injury and Illness Prevention Plan (IIPP), the WVP Program is specific to the hazards and corrective measures for the unit, service, and/or operational locations within the scope of the policy and will be available to employees at all times.

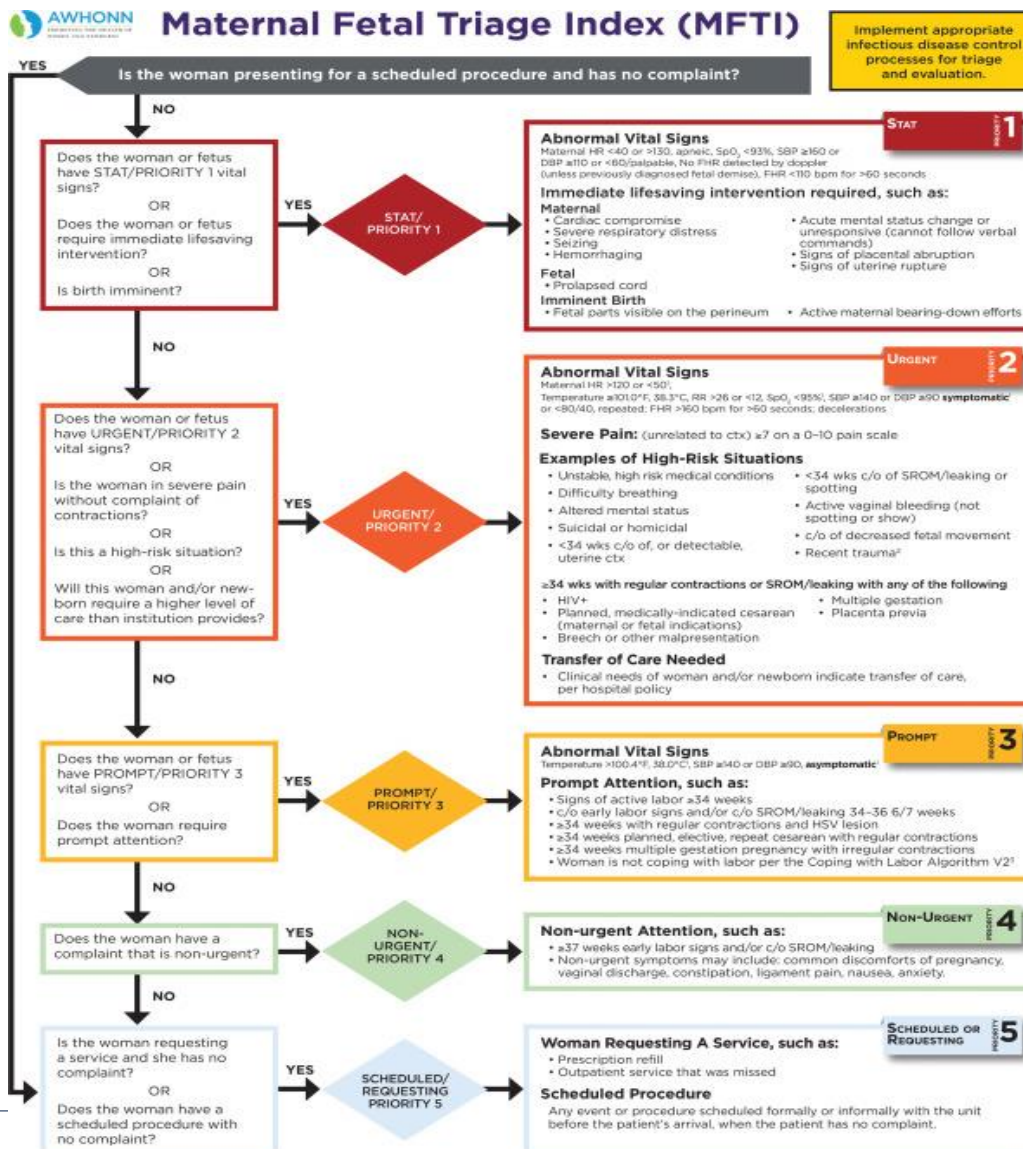
WVP Program covered by this policy includes any act of violence or threat of violence that occurs at the worksite.

Actions to Minimize Violence

In the event that you are concerned about the escalating behavior of another person, here are some suggestions to address the behavior.

DO	DO NOT
Project calmness, move and speak slowly, quietly and confidently.	Use communication that generates hostility such as apathy, the brush off, coldness, condescension. Avoid going strictly by the rules or giving the run-around.
Be an empathetic listener. Encourage the person to talk and listen patiently.	Reject all of the individual's demands from the start.
Focus your attention on the other person to let him/her know you are interested in what he/she has to say.	Pose in challenging stances such as standing directly opposite someone, hands on hips or crossing your arms. Avoid any physical contact, finger pointing or long periods of fixed eye contact.

AWHONN: Maternal Fetal Triage Index (MFTI)



¹High Risk and Critical Care Obstetrics, 2013

²Trauma may or may not include a direct assault on the abdomen. Examples are trauma from motor vehicle accidents, falls, and intimate partner violence.

³Coping with Labor Algorithm V2 used with permission

The MFTI is exemplary and does not include all possible patient complaints or conditions. The MFTI is designed to guide clinical decision-making but does not replace clinical judgement. Vital signs in the MFTI are suggested values. Values appropriate for the population and geographic region should be determined by each clinical team, taking into account variables such as altitude.

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15001





Reduction of Peripartum Racial and Ethnic Disparities: A Conceptual Framework and Maternal Safety Consensus Bundle

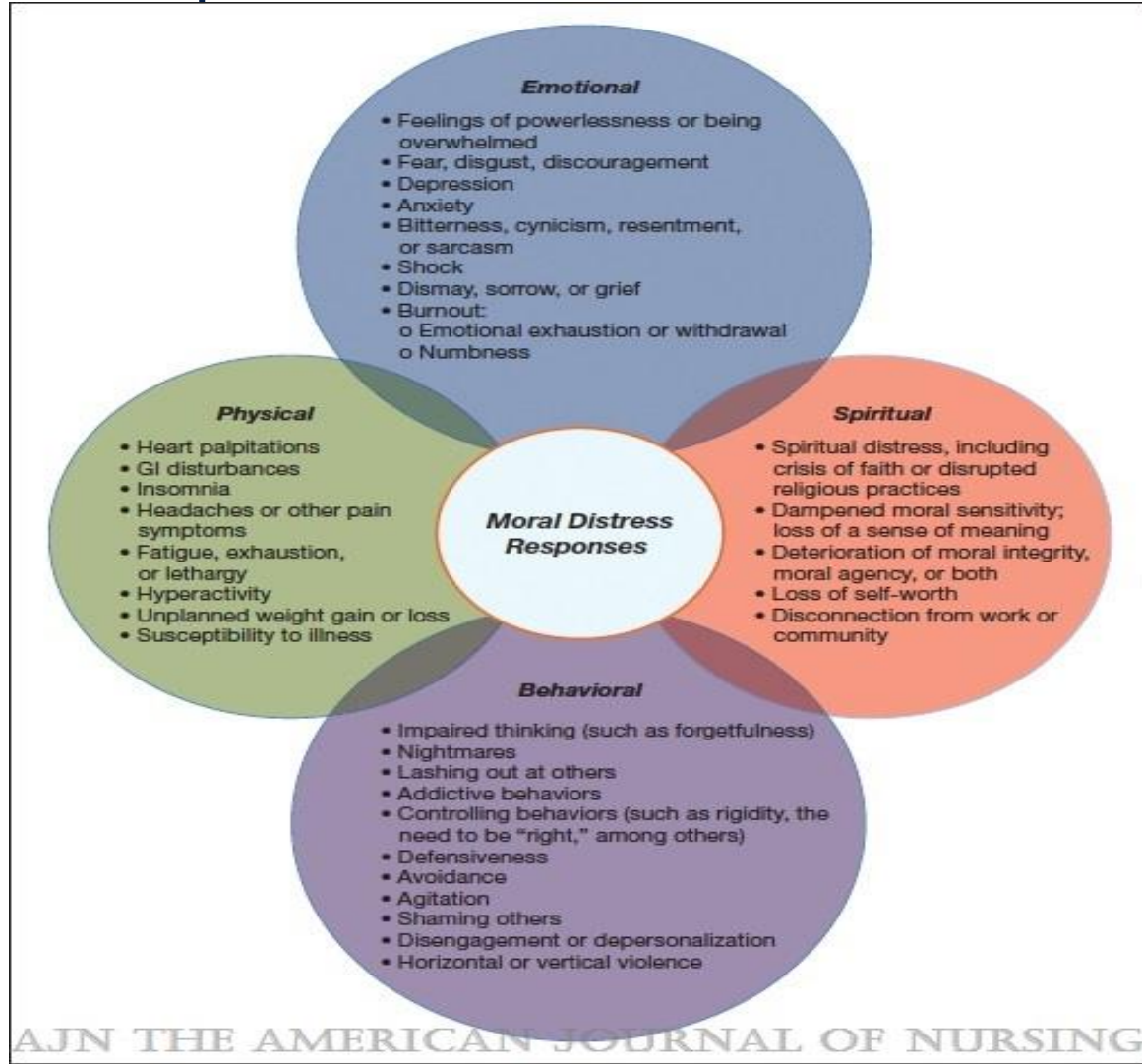
Elizabeth A. Howell, Haywood Brown, Jessica Brumley, Allison S. Bryant, Aaron B. Caughey, Andria M. Cornell, Jacqueline H. Grant, Kimberly D. Gregory, Susan M. Gullo, Katy B. Kozhimannil, Jill M. Mhyre, Paloma Toledo, Robyn D'Oria, Martha Ngoh, and William A. Grobman

The 5h R – Reduction of Disparity

- Including Intrahospital differences i.e. within an individual hospital

Moral Distress Responses

- Emotional
- Physical
- Behavioral
- Spiritual



Although nurses' primary obligation is to their patients, they also have an obligation to address their own suffering.

What Nurses Can Do to Address Moral Distress

- The American Association of Critical-Care Nurses' 2006 public policy statement on moral distress

Addressing Moral Distress requires Making Change!

4 A's

1. Ask
2. Assess
3. Act
4. Affirm



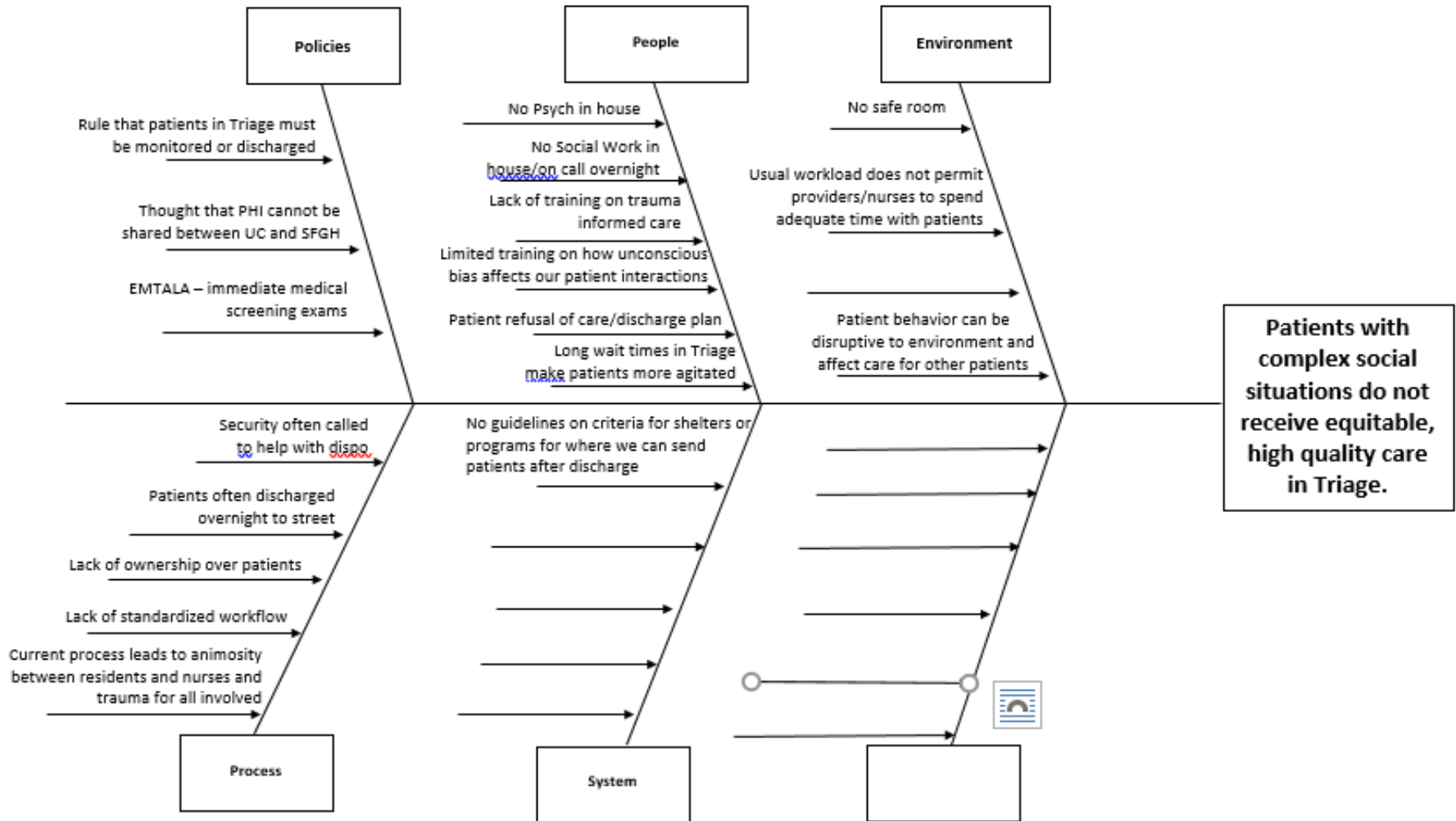
UCSF Benioff Children's Hospitals

Triage Fishbone

Psychosocial considerations

Community Resources

Improving Care of Patients in Triage



E. Nicole Teal, MD/MPH, Resident, PGY-3

Mapping out the road ahead



Summary

- Telephone triage may be a safe and cost effective means to initiate patient evaluation
- Many women present to the hospital for evaluation prior to their admission for labor and birth
- Nurses play a key role in triage and discharge
- Some nurse conduct MSE in the absence of direct evaluation by a physician per EMTALA
- Mother and baby should be stable prior to discharge
- A thorough evaluation to rule out labor and potential complications as well as confirmation of maternal-fetal well being is critical
- Utilization of AWHONN's MTFI promotes immediate recognition and multidisciplinary response aimed to prevent severe maternal morbidity and death

**Nurses are a valuable source of
information and support for women
and their families**



Thank You

